

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0916038

Reg. Dist. No.

1 9173

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3110 Texas Avenue</i>		d. STREET ADDRESS <i>3110 Texas Avenue</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Frederick</i>	Middle <i>Walter</i>	Last <i>Amorose, SR.</i>	
4. DATE OF DEATH	Month <i>Sept.</i>	Day <i>23,</i>	Year <i>1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 27, 1900</i>	
9. AGE (In years lost birthday) <i>50 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookbinder</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Louis Amorose</i>	14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Lillian J. Amorose,</i>	Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Left hemiplegia.</i> DUE TO (c) <i>Cerebral Embolism.</i>				
INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour e. m. p. m.	Month <i>Sept.</i>	Doy <i>23</i>	Year <i>1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from alive on <i>Sept 23, 1957</i> , and that death occurred at <i>10A.M.</i> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>5214 Harford Road</i>	DATE SIGNED <i>9/23/57</i>		
ACTUAL SIGNATURE <i>James E. White</i>	M.D.			
PHYSICIAN'S NAME (Type) <i>Dr. James E. White</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-26-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Maryland Park</i>	22d. LOCATION (City, town or county) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road</i>	ADDRESS	24a. REC'D. BY REGISTRAR <i>DATE 25 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. E.
RECEIVED
SEP 25 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09161

9174 CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>		c. LENGTH OF STAY IN 1b <i>x/1</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Stockton Road</i>		e. STREET ADDRESS <i>Stockton Road</i>					
3. NAME OF DECEASED (Type or print) <i>Mrs. Agnes L. Amos</i>		4. DATE OF DEATH <i>September 29th 1957</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 10, 1885</i>				
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	9. AGE (In years lost birthday) <i>72 yrs.</i> IF UNDER 1 YEAR Months Days Hours Min. Address <i>Kiel, Stockton Rd. Phoenix</i>				
13. FATHER'S NAME <i>Oswald Schulz</i>		14. MOTHER'S MAIDEN NAME <i>?</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>331X</i>		16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Mrs.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i></i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>					
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	Month <i>Sept 21st</i>	Doy <i>1957</i>	Year <i>Sept 29, 1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>York Road</i>	20f. (City or town) <i>York</i>	(County) <i>York</i>	(State) <i>Penn.</i>
21. I certify that I attended the deceased from <i>Sept 21st, 1957</i> , to <i>Sept 29, 1957</i> , that I last saw the deceased alive on <i>Sept 28, 1957</i> , and that death occurred at <i>10:30 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>M. K. Quinn</i>		ADDRESS (Street, city or town, state) <i>York Road</i>		DATE SIGNED <i>9/30/57</i>			
PHYSICIAN'S NAME (Type) <i>Dr. Kevin Quinn</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/2/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Oak Lawn Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road #14</i>		ADDRESS <i>5305 Harford Road #14</i>	24a. REC'D BY REGISTRAR DATE <i>10-2-57</i>	24b. REGISTRAR'S SIGNATURE <i>Elizabeth Gorsuch E.J.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DESAII

BUREAU Y-5
RECEIVED
OCT 2 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9175 CERTIFICATE OF DEATH

09162

Reg. Dist. No. 33

1. PLACE OF DEATH		Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
a. COUNTY	Baltimore Co.	MARYLAND	a. STATE	Maryland	b. COUNTY	Prince George Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
		1 yr. 10 mos.		Washington D.C. 16123			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Rosewood State Training School		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
				3325 - 81 st Ave. S.E.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
male	Charles	Flagg	Anderson	10/17/51	9	22	1951
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/17/51	5	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
			None	Virginia			U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
William Crawford Anderson		Flagg					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
		NO		Flagg		Aspiration pneumonia	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
351X							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) cerebral Spastic paraparesis					
{		DUE TO					
		(c) malnutrition and epilepsy					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 15, 1951, to Sept 22, 1951, that I last saw the deceased alive on Sept 21, 1951, and that death occurred at 3:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE Olive Reid Harris, M.D. Lewes St. School 9/22/51							
PHYSICIAN'S NAME (Type) Olive Reid Harris, M.D. Owings Mills, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM			
Burial		Sept 25-51		Hillside			
22d. LOCATION (City, town, or county)				(State)			
Eastport, Maine							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24. REC'D. BY REGISTRAR			
Frank H. Merrill, Bel Air, Md.				DATE 13 1951			
VS A15 (4)				24b. REGISTRAR'S SIGNATURE			
1SM 9/5/53				Mary Eline			
				E-7			

BUREAU V. S.

OCT 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9176 CERTIFICATE OF DEATH

09163
43

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Balto. MARYLAND		Md. BaItO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL and give nearest town)	
Kenwood.		15 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street, address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 Belinda Ave		14 Belinda Ave	
3. NAME OF DECEASED (Type or print)		First	Middle
Frances J. Andrews		J.	Andrews
4. DATE OF DEATH		Month	Day Year
Sept 17 1957		Month	Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
F.		W.	8. DATE OF BIRTH March 18 1890
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
67 yrs.		Months Days Hours Min.	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
At Home		House Work	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Poland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Frank Kuraya		Josephine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT		Address	
Stanley Andrews 14 Belinda Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		immediate	
331X Cerebral Hemorrhage			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b)			
Arterio sclerosis		3 yrs.	
DUE TO			
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/9 1957 to 9/17 1957 that I last saw the deceased alive on 9/17 1957, and that death occurred at 1:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
Zsigmond John Toth M.D.		DATE SIGNED 9-17-57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
BURIAL		SEPT 19-57	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
HOLY REDEEMER CEM.		4430 BELAIR RD MD.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
Offel Bros. 7110 BELAIR ROAD		RECEIVED 18 SEP 1957 Mrs. L. L. Ryerson	

RECEIVED
BUREAU X

SEP 18 1957

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9177

09164
38

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore, Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville X2		d. STREET ADDRESS 1511 Taylor Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle A. (Albert)	Last Bailey	4. DATE OF DEATH	Month 9	Day 25	Year 19 57
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 11/28/1888	9. AGE (In years (last birthday) yrs.) 68	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber - Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or Foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Bailey		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Elsie E. Bailey, 1511 Taylor Ave., Parkville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1508 Harford Rd.	(County)	(State)
21. I certify that I attended the deceased from 9-19 , 19 57 to 9-25 , 19 57 that I last saw the deceased alive on 9-25 , 19 57 , and that death occurred at 12:30 M, from the causes and on the date stated above. ACTUAL SIGNATURE L. W. Peake PHYSICIAN'S NAME (Type) Dr. C. W. Peake						ADDRESS (Street, city or town, state) Baltimore, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/28/57	22c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem Park	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc	ADDRESS 305 Harford Rd.	24a. REC'D BY REGISTRAR DATE SEP 27 1957	24b. REGISTRAR'S SIGNATURE Dell M. Jacobs				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

SEP 27 1957

REGELVÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09165

Reg. Dist. No.

41

9153

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8210 Dundalk Avenue				d. STREET ADDRESS 8210 Dundalk Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CLEDA		First	Middle	Lost	4. DATE OF DEATH Sept. 12 1957	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1902	9. AGE (in years less birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT John D. Barnwell 8210 Dundalk Avenue		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (all). (b) <u>Hypertension C-V Disease</u> DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH —								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injury</u>						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>M.B. Davis MD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) M.B. Davis MD		DATE SIGNED 9/15/57						
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Sept. 16, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Dundalk, Md.		ADDRESS		24a. REC'D BY REGISTRAR SFP 17 1957		24b. REGISTRAR'S SIGNATURE Jm. Kelly		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9154

CERTIFICATE OF DEATH

09166
41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverview		c. LENGTH OF STAY IN 1b 2 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 920 Winsap Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret	First V.	Middle Beares	4. DATE OF DEATH Sept. 21, 1957
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louis Vinyard	
14. MOTHER'S MAIDEN NAME Ida		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 443X	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
17. INFORMANT Mr. Raymond Beares, 3103 Bero Rd., Lansdowne		Address #27, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro - Vascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 443X		INTERVAL BETWEEN ONSET AND DEATH of weeks	
(b) Hyperensive C-V. disease DUE TO (c)		39 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1946 , 19, to Sept 21, 1957 , that I last saw the deceased alive on Sept 21, 1957 , and that death occurred at 12 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Edward S. Kallins PHYSICIAN'S NAME (Type) EDWARD S. KALLINS MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sep. 24/57	
22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave		24a. REC'D BY REGISTRAR SEP 24 1957 Jim Kelly	
VS A1S (4) 1SM 9/55		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S

SEP 9 1977

KELGIVEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9178

CERTIFICATE OF DEATH

09167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		b. COUNTY Baltimore	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		d. STREET ADDRESS 409 S. Rolling Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Rose	Middle E.	Last Boggess
4. DATE OF DEATH	Month Sept.	Day 9	Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1871
9. AGE (in years last birthday) 85	10. IF UNDER 1 YEAR Months 85	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Indiana	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James H. Blue	14. MOTHER'S MAIDEN NAME Phoebe Bloomer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --	16. SOCIAL SECURITY NO. --	17. INFORMANT Mrs. Miriam Kern	Address 409 S. Rolling Rd.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 2 , 19 57 , to Sept. 9 , 19 57 , that I last saw the deceased alive on Sept. 9 , 19 57 , and that death occurred at 7 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St Paul St. DATE SIGNED John A. Nesbitt, Jr. M.D.			
ACTUAL SIGNATURE JOHN A. NESBITT, JR.	PHYSICIAN'S NAME (Type)	22. LOCATION (City, town, or county) Mentone (State) Indiana	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Sept. 10-57	22c. NAME OF CEMETERY OR CREMATORIUM Mentone Cemetery	22d. LOCATION (City, town, or county) Mentone (State) Indiana
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville, Md.	ADDRESS	24a. REC'D BY REGISTRAR SEP 18 1957	24b. REGISTRAR'S SIGNATURE Reed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELY ED

BUREAU V. S.

SEP 13 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09168

Items 14 & 7 G221 10/15/57 GE

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS 607 Seabrook Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 607 Seabrook Rd.				d. STREET ADDRESS 607 Seabrook Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First MARGARET	Middle ROSE	Last BOLAND	4. DATE OF DEATH Sept. 15, 1957	Month Sept.	Day 15	Year 1957	
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1880		9. AGE (In years less than birthday) 76 yrs.	IF UNDER 1 YEAR 76 Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Patrick Sullivan				14. MOTHER'S MAIDEN NAME Margaret Daly					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Lawrence A. Kraff - 607 Seabrook Rd.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		<i>Coronary occlusion</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 		(County)	(State)
21. I certify that I attended the deceased from Sept 15, 1957 , to , 19 , that I last saw the deceased alive on Sept 15, 1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 6100 York Rd., Baltimore, Md.		DATE SIGNED Sept 16, 1957	
ACTUAL SIGNATURE <i>Frederick J. Vollmer</i>									
PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/57		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. J. Tice net & Son - Balt. 17</i>		ADDRESS 		24a. REC'D BY REGISTRAR DATE 18 Oct 1957		24b. REGISTRAR'S SIGNATURE <i>Mabel Brays</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RUNZAU V. A

SEP 19 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09169

Reg. Dist. No.

9155

41

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be mailed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Baltimore MARYLAND		a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Dundalk		Dundalk	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
35 yrs.		28 Kinship Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
William		Porter	Bosley
4. DATE OF DEATH		Month	Day
September 7		1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
		July 19, 1894	
9. AGE (In years from birth)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
63 yrs.		Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Maintenance		West Virginia	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James Bosley		Susan Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 17. INFORMANT	
WW I		213-07-4264 Oscar Staats Address 6932 Broening Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		<i>Coronary Occlusion</i>	
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL EXAMINER NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <i>9/7/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10 Sept. 1957 Oak Lawn Cemetery	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) (State) Balto. Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley Inc. Dundalk		ADDRESS	
		24a. REC'D BY REGISTRAR DATE 11-15-57	
		24b. REGISTRAR'S SIGNATURE <i>Wm. J. Kelly</i>	

RECEIVED

SEP 11 1963

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09170

9180

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		b. COUNTY BALTO.	
c. LENGTH OF STAY IN 1b 1-3 SEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX 54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 607 MACE AVE.		d. STREET ADDRESS 607 MACE AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARY	Middle FRANCES	Last BOURNE
4. DATE OF DEATH	Month SEPT.	Day 5	Year 19 57
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 8-1869
9. AGE (In years lost birthday) 87 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
13. FATHER'S NAME JAMES MORRIS	14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT WM. E. BOURNE	Address SAME AS ABOVE
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerotic Generalized DUE TO (c) Cadila - Vardenafil (and others) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Cerebral Hemorrhage (intra cerebral & subarachnoid) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury to head		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year 1957
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) BALTIMORE	(County) MARYLAND
(State) MD			
21. I certify that I attended the deceased from Sept. 10, 1957 , to Sept. 15, 1957 , that I last saw the deceased alive on Sept. 5, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 3003 Beaver Dam St., Bel Air, Md.			
DATE SIGNED Sept. 15, 1957			
ACTUAL SIGNATURE William W. Alexander			
PHYSICIAN'S NAME (Type) William W. Alexander, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 6 1957	22c. NAME OF CEMETERY OR CREMATORIUM BEAVER DAM	22d. LOCATION (City, town, or county) FLOVANNA
(State) VA.			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly			
ADDRESS 418 Eastern Ave. Bel Air, Md.			
24a. REC'D BY REGISTRAR SEP 9 1957			
24b. REGISTRAR'S SIGNATURE Eduard Farley			
B-46-21 mt			

BUREAU V. S.

SFP 9 1977

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09171

9181

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b one month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS 528 Yale Avenue				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Mollie		First Ellen	Middle Bowen	Last Bowen	4. DATE OF DEATH Sept. 22, 1957	Month Sept.	Day 22	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH June 22, 1889	9. AGE (In years last birthday) 68 yrs	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 8	12. IF UNDER 24 HRS. Hours 12	13. IF UNDER 24 HRS. Min. hrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.				
12. CITIZEN OF WHAT COUNTRY? U. S. A.								
13. FATHER'S NAME Edward Platt				14. MOTHER'S MAIDEN NAME Ida DeUnger				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Clifton Bowen 444 Random Rd., Baltimore, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 ? X DUE TO Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH 12 hrs				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Gangrene toes 2. abscess left hip				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2. February, 1957, to 24 September, 1957.						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 715 Frederick Road, Catonsville 28, Md.		20f. (City or town) (County) (State) 715 Frederick Road, Catonsville 28, Md.		
21. I certify that I attended the deceased from February, 1957, to 24 September, 1957. that I last saw the deceased alive on 21 September, 1957 , and that death occurred at 2A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 715 Frederick Road, Catonsville 28, Md.								
DATE SIGNED September 24, 1957								
ACTUAL SIGNATURE James E. Rowe								
PHYSICIAN'S NAME (Type) James E. Rowe		22d. LOCATION (City, town, or county) Baltimore, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 24, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Easton Jones		ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR SEP 26 '57		24b. REGISTRAR'S SIGNATURE John L. Smith		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

7-2 95 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9182

CERTIFICATE OF DEATH

Reg. Dist. No. 0917241

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 32 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2707 W. North Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GEORGE		First -----	Middle -----	Last BROWN	4. DATE OF DEATH September	Month 18	Day 19	Year 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 31, 1908	9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Pool Room		11. BIRTHPLACE (State or foreign country) Buckingham County, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Matt Brown		14. MOTHER'S MAIDEN NAME Janie Mosley							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 218-05-0408		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO RENAL FAILURE						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)						UNKNOWN			
DUE TO PYELONEPHRITIS CHRONIC (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA		20f. (City or town) VAH, FORT HOWARD, MARYLAND		(County)	(State)
21. I certify that I attended the deceased from August 17, 1957 , to September 19, 1957 , and that death occurred at 5:55 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>H. R. Johnson</i>								ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D.								DATE SIGNED 9/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-57		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802-04 Madison Ave., Balt.		ADDRESS 1, Md.		24. REC'D BY REGISTRAR SEP 20 1957		24b. REGISTRAR'S SIGNATURE Lawson L. Farber			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

SEP 2 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film 4221, 74/57

CERTIFICATE OF DEATH

0917331

Reg. Dist. No.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gwyn Oak	c. LENGTH OF STAY IN 1b 3 Yrs	b. COUNTY Montgomery	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore/Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Home		d. STREET ADDRESS 2406 Lindell St Silver Spring		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary R. Brown	First	Middle	Last	
4. DATE OF DEATH September 28, 57	Month	Day	Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 28, 1878	
9. AGE (In years lost birthday) 79 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Balto Co.	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Williamson Roe		14. MOTHER'S MAIDEN NAME Amanda Hooper		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; unknown) No	16. SOCIAL SECURITY NO. -----	17. INFORMANT Records Ausburg Home 6811 Campfield Rd.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Cancer of stomach - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - Cancer of stomach DUE TO (c)				
			INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (1) - Vascular bleed of leg -				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4108 Liberty Hts Balto - 9-3-57	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 12, 1957 to Sept 28, 1957 , that I last saw the deceased alive on Sept 28, 1957 , and that death occurred at 4108 Liberty Hts Balto - 9-3-57 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4108 Liberty Hts Balto - 9-3-57				
ACTUAL SIGNATURE Earl L. Chambers	DATE SIGNED 9-3-57			
PHYSICIAN'S NAME (Type) Earl L. Chambers				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sep. 30 57	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cem.	22d. LOCATION (City, town, or county) Balto Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Paul A. Heemann		ADDRESS 6067 Harford Rd.	24a. REG'D BY REGISTRAR 301	24b. REGISTRAR'S SIGNATURE Dr. John Martin
			DATE 9-3-57	

BUREAU Y.

11-1-1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Belvoir, VA						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS Spring Grove State Hospital						
3. NAME OF DECEASED (Type or print)		First GORDON	Middle W.	Last BROOME Sr	4. DATE OF DEATH	Month September	Day 19	Year 19		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 0	Days 0	IF UNDER 24 HRS. Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norwalk, Conn			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
				049-18-2583		Rudolf W. Gravem Jr., U.S. Army				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic and hypertensive cardiovascular disease 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) R. Fisher		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12-12-1957				
22a. BURIAL, CREMATION, REMOVAL (Check)		22b. DATE THEREOF Sept 16-57		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Crematorium		22d. LOCATION (City, town, or county) Colma, Marin, CA		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Albert Edward Lewis, Jr.		ADDRESS		24a. REG'D BY REG'D DATE SEP 1957		24b. REGISTRAR'S SIGNATURE O. Fisher				

REGELIVEL
BUNNAD V. 2

1957

1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09175

9185

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1 PLACE OF DEATH a. COUNTY Baltimore			MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 16 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3717 Croyden Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital										
3. NAME OF DECEASED (Type or print)		First JACOB	Middle S.	Last BUCHER	4. DATE OF DEATH	Month September	Day 30	Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1900		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS Days 7	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Typewriter Repairs		11. BIRTHPLACE (State or foreign country) Rexmont, Pennsylvania		12. CITIZEN OF WHAT COUNTRY U. S. A.				
13. FATHER'S NAME Jonas Bucher			14. MOTHER'S MAIDEN NAME Olivia Snyder							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 219-10-5639		17. INFORMANT Clin. Rec., Vet. Administration, Ft. Howard, Md.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF RECTUM WITH METASTASES TO LIVER AND ABDOMINAL LYMPH NODES INTERVAL BETWEEN ONSET AND DEATH UNKNOWN X 4 X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO _____ (c) _____										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Operation: Right transverse colostomy - 9/19/57										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) XX-XXXX-XXXX-XXXX-XXXX-XXXX-XXXX-XXXX , and that death occurred at _____ M, from the causes and on the date stated above ADDRESS (Street, city or town, state)								
20c. TIME OF INJURY Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) VA HOSPITAL, FT. HOWARD, MD.		(City or town) VA HOSPITAL, FT. HOWARD, MD.		(County) VA HOSPITAL, FT. HOWARD, MD.	(State) VA HOSPITAL, FT. HOWARD, MD.	
21. I certify that I attended the deceased from September 17, 1957 , to September 30, 1957 , XX-XXXX-XXXX-XXXX-XXXX-XXXX-XXXX-XXXX , and that death occurred at _____ M, from the causes and on the date stated above ADDRESS (Street, city or town, state)										
ACTUAL SIGNATURE Chien Wei Lan		DATE SIGNED 9/30/57								
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-57		22c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery		22d. LOCATION (City, town, or county) Pikesville, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Frank Newell		ADDRESS Pikesville, Maryland		24b. READ BY REGISTRAR D. L. Farber		24c. REGISTRAR'S SIGNATURE D. L. Farber				

BUREAU V. S

OCT 3 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9186

CERTIFICATE OF DEATH

09176 44
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard,		c. LENGTH OF STAY IN 1b 38 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 5203 St. Georges Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES		First CHARLES	Middle O.	Lost BUTTOLPH	4. DATE OF DEATH Month September 30
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 26, 1890	9. AGE (In years last birthday) 67	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Finisher		10b. KIND OF BUSINESS OR INDUSTRY Bowling Alley		11. BIRTHPLACE (State or foreign country) Potsdam, New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Austin Buttolph		14. MOTHER'S MAIDEN NAME Nina Stearns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO 096-05-3823		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COMMON BILE DUCT WITH METASTASES TO LYMPH REGIONAL LYMPH NODES				INTERVAL BETWEEN ONSET AND DEATH 155X 6 MONTHS	
Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obstructive Jaundice due to (a) Operation - Exploratory Laparotomy - 9/17/57				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
VA		VA			
21. I certify that attended the deceased from August 23, 1957 , to September 30, 1957 , and that death occurred at 10:30AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Chien Wei Lan</i>		M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 9/30/57			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-57		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Maryland				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. St. Paul & Preston Sts., Balto, Md.		ADDRESS		24. REC'D BY REGISTRAR DATE OCT 2 1957	
				REGISTRAR'S SIGNATURE <i>L. G. Gandy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PUREAU V. S.

OCT 2 1957

KELLOGG

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9187

CERTIFICATE OF DEATH

09177
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. - b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		d. STREET ADDRESS 11 S. Beechwood Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Carrie	Middle V.	Last Carter
4. DATE OF DEATH	Month Sept.	Day 21	Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1877
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY Virginia Lighthouser	
13. FATHER'S NAME John Bishop		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT		Address Calvin Carter 1502 Ivanhoe Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Probable Kaposi's sarcoma of skin</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>4-7-57</u> , 19 <u>57</u> , to <u>9-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-20</u> , 19 <u>57</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John Nesbitt Jr.</i>		ADDRESS (Street, city or town, state) 1115 St Paul St.	
PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-24-57	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem.	22d. LOCATION (City, town, or county) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville Md.		24a. REC'D BY REGISTRAR Sept. 25, 1957	
		24b. REGISTRAR'S SIGNATURE G. J. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

RECEIVED
BUREAU V. S.

SEP 25 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9188

CERTIFICATE OF DEATH

09178

Reg. Dist. No.

30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 72 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 604 Alvin Avenue				d. STREET ADDRESS 604 Alvin Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ida		First	Middle Rena	Lost Clark	4. DATE OF DEATH Sept. 30,	Month Sept.	Day 30	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	B. DATE OF BIRTH Jan. 7, 1885	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Henry Grine			14. MOTHER'S MAIDEN NAME Alverta Skidmore					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Margaret Payne		Address 605 Alvin Ave. Catonsville		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH Immediate								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease 5 years. DUE TO (c) Diabetes Mellitus								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 10, 1950 , to Sept 30, 1957 , that I last saw the deceased alive on Sept 28, 1957 , and that death occurred at 2 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE William F. Grassaway		M.D.		ADDRESS (Street, city or town, state) Ellicott City, Md.			DATE SIGNED 9/30/57	
PHYSICIAN'S NAME (Type) William F. Grassaway M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/3/1957		22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Easton Jones		ADDRESS Catonsville, Md.		24a. RECEIVED BY REGISTRAR Oct 3, 1957		24b. REGISTRAR'S SIGNATURE John L. Brown		
				DATE Oct 3, 1957				

SHIRLEY V. S

OCT 3 1957

REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9189

CERTIFICATE OF DEATH

09179

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 18 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First HUGH	Middle C	Last CLOWER	
4. DATE OF DEATH September 29 1957	Month September	Day 29	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 1, 1874	
9. AGE (In years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 82	11. IF UNDER 24 HRS. Days 0	12. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager	10b. KIND OF BUSINESS OR INDUSTRY Laundry	11. BIRTHPLACE (State or foreign country) Wheatfield, Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Clewer	14. MOTHER'S MAIDEN NAME Francis MN: Unknown.	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES	16. SOCIAL SECURITY NO. SAW 216-05-0827	17. INFORMANT Clin Rec, Vet Adm Hosp. Ft. Howard, Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASIS TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. XOOGS (b) LUNGS, LIVER AND ABDOMINAL LYMPH NODES. DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that V attended the deceased from Sept. 11, 1957 , to Sept. 29, 1957 X X and that death occurred at 2:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Chien Wei Lan</i> DATE SIGNED PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. M.D. Veterans Administration Hospital 9/29/57				
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 10/29/57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	22d LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tuckner	ADDRESS Wilson Blvd. Arlington, Va.	24a. REC'D BY REGISTRAR DATE 9/30/57	24b. REGISTRAR'S SIGNATURE Deacon L Farley	

BUREAU V.

ACT 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09180
38

9190 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore Maryland				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 20 years		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 625 Valley Lane				d. STREET ADDRESS 625 Valley Lane				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Richard	Middle Daniel	Last Cole	4. DATE OF DEATH September	Month 28	Day 19	Year 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 5, 1900	9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Developer			10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Malden, Mass.			
13. FATHER'S NAME Nehemiah Thomas Cole				14. MOTHER'S MAIDEN NAME Maude Farnham				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-5868		17. INFORMANT Mrs. Gladys Cole		Address 625 Valley Lane Baltimore, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 15 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 mos.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May 10, 1957</u> to <u>Sept 28, 1957</u> , that I last saw the deceased alive on <u>Sept 28, 1957</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 1/30/57								
ACTUAL SIGNATURE George Sawyer		M.D. 4808 Harford Rd						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF October 1, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Fun'l Home		ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR DATE 1/30/57		24b. REGISTRAR'S SIGNATURE R. L. M. Sawyer		

BUREAU V.

OCT 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 2. State Police 9191 Item 9. Block 2, File No. 1-1-57 et		Reg. Dist. 09185									
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Florida</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkton</i>		c. LENGTH OF STAY IN 1b <i>0</i>		b. COUNTY <i>Dania</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>1304 Sta. A. (</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Manuel P. G. Colon</i>		First <i>Manuel</i>	Middle <i>P. G.</i>	Last <i>Colon</i>	4. DATE OF DEATH <i>Sept. 28</i>	Month <i>Sept.</i>	Day <i>28</i>	Year <i>1957</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Unknown</i>	9. AGE (in years last birthday) <i>13 ? yrs.</i>	IF UNDER 1 YEAR Months <i>13</i>	IF UNDER 24 HRS. Days <i>?</i>	Hours <i>0</i>	Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>					
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Fractures & Crushing</i> DUE TO <i>816x</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Body injuries</i> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Automobile accident</i>									
20c. TIME OF INJURY Month, Day, Year <i>12 a.m. 9/28 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rt 111</i>		20f. (City or town) <i>Fairfax, Balt</i>		(County) <i>Md</i>		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>A.M. France</i>		DATE SIGNED <i>9/28/57</i>									
EXAMINER'S NAME (Type) <i>A.M. France</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-16-57</i>		22b. DATE THEREOF <i>10-16-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>U. of Md. Med. School</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chester L. Fuller</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>10/1/57</i>		24b. REGISTRAR'S SIGNATURE					

1294 Ste 1

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BURPAW Y

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

Item 2 State Pd MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
919 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

091825

Reg. Dist. No.

1. FATHER'S DEATH a. COUNTY <i>Baltimore</i>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Florida</i> b. COUNTY <i>Dade</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PARKTON</i>	c. LENGTH OF STAY IN 1b <i>No Inv</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS <i>West Baltimore</i> 48X 2

3. NAME OF DECEASED (Type or print)	First <i>Sixto</i>	Middle <i>Agosto</i>	Last <i>Colo</i>	4. DATE OF DEATH <i>Sept. 28</i>	Month	Day	Year
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5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <i>29 yrs.</i>	IF UNDER 15 YRS. Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Unknown</i>	12. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>
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13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT
---	-------------------------	---------------

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH <i>0</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MULTIPLE FRACTURES + CRUSHING BODY</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>injuries</i>			
DUE TO (b) <i>injuries</i>			
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>AUTO MOBILE ACCIDENT</i>		
20c. TIME OF INJURY Month, Day, Year <i>12:30 a.m. 9/28 1957</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Art. II</i>	20f. (City or town) <i>PARKTON BOSTON MD</i>
(County) <i>Baltimore County</i>	(State) <i>Maryland</i>		

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>				
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ACTUAL SIGNATURE <i>A. M. France</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>9/28/57</i>
EXAMINER'S NAME (Type) <i>A. M. FRANCE</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-15-57</i>	22b. DATE THEREOF <i>10-15-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL S. of Md. Med. School	22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>
(State)	(State)	(State)	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chester L. Fullerton</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>10/1/57</i>	24b. REGISTRAR'S SIGNATURE

238 - 4.16. 1960

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BURKARD V. S

52:

PROBLEMS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9193 CERTIFICATE OF DEATH

09183

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anneslie (Baltimore 12)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		d. STREET ADDRESS 519 Dunkirk Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First JOHN	Middle D	Last COSTLOW	4. DATE OF DEATH	Month September	Day 12	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1983	9. AGE (In years (last birthday) 26 7/3 yrs.	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 1	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personnel Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Auto Agency		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel Costlow				14. MOTHER'S MAIDEN NAME Catherine Sweeney				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. John D. Costlow, 519 Dunkirk Rd., Balto., Md.		Address		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arterio-Sclerosis INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Hypertension ONSET AND DEATH 2 days</p> <p>(b) Cerebral Hemorrhage 5 yrs ago & continuing</p> <p>(c) Cerebral Hemorrhage 5 yrs ago & continuing</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Maryland
<p>21. I certify that I attended the deceased from June, 1957, to Present, that I last saw the deceased alive on Sept. 12, 1957, and that death occurred at 7:30 P.M., from the causes and on the date stated above.</p> <p>ACTUAL SIGNATURE Mabel C. Gray</p> <p>PHYSICIAN'S NAME (Type)</p> <p>ADDRESS (Street, city or town, state) 1403 Park Ave Baltimore MD</p> <p>DATE SIGNED Sept. 13, 1957</p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF Sept. 14, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Crematory			22d. LOCATION (City, town, or county) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John Bush Sons,	ADDRESS Towson, Md.	24a. REC'D BY REGISTRAR Sept. 13, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray				

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BUREAU V. A.

SFP 16 1957

SEARCHED INDEXED SERIALIZED FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G221 10-8-57 et

09184

9156

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD		b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		d. STREET ADDRESS 126 VENTNOR TERRACE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 126 VENTNOR TERRACE				d. STREET ADDRESS 126 VENTNOR TERRACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATE KENNEDY	First Louvenia	Middle King	Last CROMER	4. DATE OF DEATH 9 - 30 - 1957	Month 9	Day 30	Year 1957
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26-1898	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George King		14. MOTHER'S MAIDEN NAME Virginia Mason		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Gladis Dean - 126 Ventnor Terrace		INTERVAL BETWEEN ONSET AND DEATH 2 months	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Carcinoma Stomach.		DUE TO Diabetes Mellitus		10 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Hypertension.		DUE TO 10 years		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 33 Dundalk Ave		(City or town) (County) (State) Harrisonburg, Virginia	
21. I certify that I attended the deceased from Jan 1, 1957 to Sept 30, 1957 , that I last saw the deceased alive on Sept 28, 1957 , and that death occurred at VA M , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 33 Dundalk Ave 9/30/57							
ACTUAL SIGNATURE David H. Andrew		M.D.		DATE SIGNED 9/30/57			
PHYSICIAN'S NAME (Type) David H. Andrew							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-2-57		22c. NAME OF CEMETERY OR CREMATORIUM Woodbine Cemetery		22d. LOCATION (City, town, or county) Harrisonburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Lindley Funeral Home, Harrisonburg, Virginia		ADDRESS		24a. REC'D. BY REGISTRAR Oct 1 1957		24b. REGISTRAR'S SIGNATURE J. M. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU K-6
REGRILLE

OCT 1 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9194 CERTIFICATE OF DEATH

09185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 2716 Frederick Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2716 Frederick Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) HOWARD M CROSS		First	Middle	Last	4. DATE OF DEATH Sept. 13	Month	Doy	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1880	9. AGE (In years from last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming-Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Henson Cross				14. MOTHER'S MAIDEN NAME Mary Knight				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-10-7262		17. INFORMANT Herman A. Miller, Catonsville, Md		Address THURMAN		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				Generalized carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 6 MOS		
				CARCINOMA OF STOMACH				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) COLUMBIA	(County) MD	(State) MD
21. I certify that I attended the deceased from 5-9 , 1957, to 9-13 , 1957, that I last saw the deceased alive on 9-13 , 1957, and that death occurred at 7:45 PM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) ELLIOTT CITY, MD								
DATE SIGNED Peter V. Thorpe								
ACTUAL SIGNATURE Peter V. Thorpe								
PHYSICIAN'S NAME (Type) F.C. Higinbotham, Ellicott City, Md								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-16-57	22c. NAME OF CEMETERY OR CREMATORIAL St. Johns		22d. LOCATION (City, town, or county) Ellicott City, Md		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR 16 57		24b. REGISTRAR'S SIGNATURE P. J. Higinbotham		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 16 195

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09186
20

9195 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN Tb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS 3235 Magnolia Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Coleine	Last Curtin	4. DATE OF DEATH September	Month	Day 22	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 4, 1910	9. AGE (In years at birthday) 47 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Md. Glass Corp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Homer Curtin			14. MOTHER'S MAIDEN NAME Hattie Coleine				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) Yes		16. SOCIAL SECURITY NO. W.W. II 213-01-1120		17. INFORMANT Mrs. Pauline Curtin		Address 3235 Magnolia Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Friedreich's Ataxia DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 20 19 57 to Sept. 22 19 57 , that I last saw the deceased alive on Sept. 22 19 57 , and that death occurred at 7:20p M , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Stella Wachler</i>		M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 9-23-57		DATE SIGNED	
PHYSICIAN'S NAME (Type) Stella Wachler, M. D.		Catoonsville 28, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-57		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				ADDRESS		24a. REC'D BY REGISTRAR SEP 24 '57	24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REFILED

SEP 25 1964

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09187

9196 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 22 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 115 Port Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First THEODORE	Middle ---	Last DE SHIELDS	4. DATE OF DEATH September 18	Month 18	Day 19	Year 57
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1896	9. AGE (In years lost birthday) 61 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - gardener		10b. KIND OF BUSINESS OR INDUSTRY Nursery		11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William De Shields		14. MOTHER'S MAIDEN NAME Pricilla Viney					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or unknown) Yes W.W.I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO-INTESTINAL HEMORRHAGE						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
17X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b) ADENOCARCINOMA OF STOMACH WITH LIVER METASTASIS				UNKNOWN	
DUE TO (c)						UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VAH, FORT HOWARD, MARYLAND	(County)	(State)	
21. I certify that VAH attended the deceased from August 27, 1957 , to September 18, 1957 , and death occurred at 4:50 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 9/18/57	
ACTUAL SIGNATURE HAROLD R. JOHNSON, M.D.							
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-20-57	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802 Madison Ave. Balto., Md.		ADDRESS Sept. 25, 57	24a. REG'D BY REGISTRAR Dawson L. Fahey	24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DUANE K. S.

SFP

WISCONSIN

09188

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
91 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for 4 years.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVE		c. LENGTH OF STAY IN TB MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MARTIN BLVD. & RIVERTON RD.		e. STREET ADDRESS 401 N PORT STREET	
3. NAME OF DECEASED (Type or print) WILLIAM		First DURHAM	Middle DURHAM
Last DURHAM		4. DATE OF DEATH SEPT. 21	Month 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-31
9. AGE (In years less birthday) 26 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR	10b. KIND OF BUSINESS OR INDUSTRY NATIONAL CASH CO	11. BIRTHPLACE (State or foreign country) BALTIMORE MD	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ABRAHAM DURHAM		14. MOTHER'S MAIDEN NAME RACHEL CAMBELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 400-349-380	
17. INFORMANT KOREAN WAR		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Fracture of Skull - DUE TO 8:28 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 1/2 STAND	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Crashed by car overturning		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Car over turned throwing victim out		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car over turned throwing victim out	
20c. TIME OF INJURY Hour 4 Month, Day, Year 9-21 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 9-21-57	
ACTUAL SIGNATURE <i>John Collier</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Collier		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF SEPT 24 1957		22c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL CEM	
23. FUNERAL DIRECTOR'S SIGNATURE Clifford Bros 1800 E LOMBARD ST		22d. LOCATION (City, town, or county) (State) 5501 FREDERICK RD MD	
ADDRESS 1800 E LOMBARD ST		24a. REC'D BY REGISTRAR SEP 23 1957	
		24b. REGISTRAR'S SIGNATURE Edith Hurley	

REF ID:

BUREAU N.Y.

SEP 23 1957

REG'D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09189

Reg. Dist. No. 45

FOR STATE
HEALTH DEPT.

PLAID TYPE, OR WRITE WITH BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
Every item of information should be completed. Physicians please write the causes of death clearly and legibly.

9198

1. NAME OF DECEASED (Type or Print)		FRANKLIN D EMANUEL		2. DATE OF DEATH 9-21-57	
3. PLACE OF DEATH A. Baltimore City <input checked="" type="checkbox"/> Baltimore County <input type="checkbox"/>		4. USUAL RESIDENCE A. STATE Md.		(Where deceased lived. If institution, residence before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION Martin Blvd. and Riverton Rd.		C. CITY OR TOWN Baltimore		(If outside corporate limits, write RURAL and give township) Vol 4	
c. LENGTH OF STAY IN BALTIMORE 3 years		Yrs. Mos. Days			
5. SEX M W		6. COLOR OR RACE		7. SINGLE, MARRIED, (INCLUDES) WIDOWED, DIVORCED Single	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shopman		10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.		8. DATE OF BIRTH 2-28-37	
13. FATHER'S NAME James Emanuel		16. SOCIAL SECURITY NO. none		9. AGE (In years birthday) 20	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		17. INFORMANT Steve Brewer 1323 Gage Ct.		10. CITIZEN OF USA WHAT COUNTRY?	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO CRUSHING INJURY OF CHEST		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST		(B) DUE TO			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II.		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) INJURY OCCURRED MARTIN BLVD & RIVERTON RD	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 9-21-57-4A.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? AUTO OVERTURNED	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. SIGNATURE R.W. Brewer		23b. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER M.D. MEDICAL INVESTIGATOR		23c. DATE SIGNED 9-21-57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-24-57		24c. NAME OF CEMETERY OR CREMATORIAL zion Hill Baptist Cemetery	
DATE RECEIVED BY REGISTRAR 9-21-57		REGISTRAR'S SIGNATURE Edith Hulett		25. FUNERAL DIRECTOR Frank Cwach & Son 900 N. Chester St.	

BUREAU V. S.

SEP 19 1968

REGELV E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9199 CERTIFICATE OF DEATH

09190

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Baltimore MARYLAND		a. STATE Md.	b. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7122 MARSTON Rd.		d. STREET ADDRESS 7122 MARSTON Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ALICE	Middle J.	Last FICKES
4. DATE OF DEATH	Month Sept	Day 13	Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1892
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Work for Sunpaper Co		11. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? Pennsylvania USA	
13. FATHER'S NAME John Waller		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT 172-01-3258 Mr. Bennett Fickes 7122 MARSTON Rd BALTIMORE Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 15 min	
(b) DUE TO Arterosclerotic Hypertensive cardio- vascular disease		years	
(c) DUE TO obesity			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> p. m. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1957, to Aug, 1957 that I last saw the deceased alive on Aug, 1957 and that death occurred at 2 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED		20f. (City or town) ADDRESS (Street, city or town, state) DATE SIGNED	
MEDICAL CERTIFICATION NOTICE PHYSICIAN'S SIGNATURE NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Sept 16, 57		22c. NAME OF CEMETERY OR CREMATORIAL Springville Cemetery	
22d. LOCATION (City, town, or county) Boiling Spring P.H.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Elmer & Sons Reis Town. 14d		24c. REC'D BY REGISTRAR DATE 9-13-57	
		24b. REGISTRAR'S SIGNATURE Mary B. Elmer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.
SEP 17 1957
S. 102 (1957-58)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09131
44

Reg. Dist. No.

92-10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
		b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS PT Baltimore		c. LENGTH OF STAY IN 1b WORK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (DUNDAK)	
3. NAME OF DECEASED (Type or print) Charles SHERWOOD		4. DATE OF DEATH Last Month Day Year Fish, SR 9 19 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY 2, 1918 39 yrs.
9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheeter	
10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH FISH	
14. MOTHER'S MAIDEN NAME IDA JOHNSON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes, give war or date of service) W.W. II	
16. SOCIAL SECURITY NO. 739-24-4429		17. INFORMANT LEONA GREGORY FISH — SAME Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) 1 INSTANTANEOUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO fracture of skull (c)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 102.3		Crushing injury of head & Compound fracture of skull	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from roof		20c. TIME OF INJURY Month, Day, Year 8:55 a.m. 9-19-57	
20d. INJURY OCCURRED White at work <input checked="" type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bethlehem Steel Co. Baltimore	
20f. (City or town) (County) (State) 19 Md.		20g. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 9-19-57	
ACTUAL SIGNATURE JACK COLLINS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JACK C. COLLINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
M.D. B. DAVIS, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/22/57	
22c. NAME OF CEMETERY OR CREMATORIAL FACILITY LILLINGTON, N.C.		22d. LOCATION (City, town, or county) LILLINGTON, N.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter Bender Bradley, Standard 22, M.D.		24a. REC'D. BY REGISTRAR JEP 23 1957	
		24b. REGISTRAR'S SIGNATURE	

BUREAU Y. &

SEP 22 1962

KIESELVEM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09192

CERTIFICATE OF DEATH

Reg. Dist. No.

9201

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE		b. COUNTY BALTIMORE				
c. LENGTH OF STAY IN 1b SPRING AVE.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING AVE.		d. STREET ADDRESS SPRING AVE.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) KRISTINA HATTIE B. FISHER		First KRISTINA	Middle HATTIE			
3. NAME OF DECEASED (Type or print) KRISTINA HATTIE B. FISHER		3. NAME OF DECEASED (Type or print) KRISTINA HATTIE B. FISHER	Last FISHER			
4. DATE OF DEATH SEPT. 30, 1957		Month SEPT.	Day 30			
4. DATE OF DEATH SEPT. 30, 1957		Year 1957				
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH NOV. 30, 1879		8. AGE (In years last birthday) 77 yrs.	9. IF UNDER 1 YEAR: IF UND. 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND USA			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EMANUEL FISHER				
14. MOTHER'S MAIDEN NAME Laura Royston		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, unknown) NO				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, unknown) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT FAMILY RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.				
4. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Cardiac Failure DUE TO (c) Aortic insufficiency				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1	20f. (City or town) LUTHERVILLE, MD	(County) LUTHERVILLE, MD	(State) MARYLAND
21. I certify that I attended the deceased from Sept. 1, 1957 , to Sept. 3, 1957 , that I last saw the deceased alive on Sept. 2, 1957 , and that death occurred at 8:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE G. T. GILMORE M.D.		ADDRESS (Street, city or town, state) LUTHERVILLE, MD		DATE SIGNED Sept. 5, 1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 6, 1957	22c. NAME OF CEMETERY OR CREMATORIUM POPLAR GROVE CEM.	22d. LOCATION (City, town, or county) COCKEYSVILLE, MD.	(State) MARYLAND	
22e. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md.		22f. ADDRESS John Burns' Sons, Towson, Md.	22g. REC'D. BY REGISTRAR Sept. 5, 1957	22h. REGISTRAR'S SIGNATURE Mabel C. Gray		

DE ALLEGDK

SEP 6 1957

BUHLAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9292

CERTIFICATE OF DEATH

09193
283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	b. COUNTY <i>Balto.</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings</i>	c. LENGTH OF STAY IN 1b <i>6 mo</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>103 W. Fuller</i>	d. STREET ADDRESS <i>103 W. Fuller Ave</i>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>103 W. Fuller Ave</i>	d. STREET ADDRESS <i>103 W. Fuller Ave</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <i>Edward Bernard Fowler</i>	First <i>E</i>	Middle <i>Edward</i>	Last <i>Fowler</i>	4. DATE OF DEATH Month <i>Sept</i>	Day <i>9</i>	Year <i>1957</i>						
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Sept 24 1942</i>	9. AGE (In years lost birthday) <i>14 yrs</i>	10. IF UNDER 1 YEAR Months <i>14</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. CITIZEN OF WHAT COUNTRY? Hours <i>0</i>	13. Months <i>0</i>	14. Days <i>0</i>	15. Hours <i>0</i>	16. Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At School</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>No h</i>	11. BIRTHPLACE (State or foreign country) <i>Balto. Co.</i>	12. COUNTRY OF BIRTH <i>U.S.A.</i>							
13. FATHER'S NAME <i>Sterling Fowler</i>			14. MOTHER'S MAIDEN NAME <i>Barbara G. Langner</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give rank and date of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Sterling Fowler</i>	Address <i>103 W. Fuller Ave</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i>												
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Sarcoma</i>												
DUE TO (c) <i>Reticulum cell Sarcoma</i>												
INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>												
18 months												
2 years												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <i>Towson</i>		(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>July</i> , 19 <i>56</i> , to <i>September 9</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>September 9</i> , 19 <i>57</i> , and that death occurred at <i>Towson</i> , Md., from the causes and on the date stated above.												
ACTUAL SIGNATURE <i>Paul G. Mueller</i>												
PHYSICIAN'S NAME (Type) <i>PAUL G. MUELLER</i>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Sept 13-57</i>			22b. DATE THEREOF <i>Sept 13-57</i>			22c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood Cem.</i>			22d. LOCATION (City, town, or county) <i>Taylor Ave Batt. Co. Md.</i>			
(State) <i>Md.</i>												
22e. FUNERAL DIRECTOR'S SIGNATURE <i>Doppel Bros. 7110 Belair Rd.</i>			ADDRESS <i>7110 Belair Rd.</i>			24a. REC'D BY REGISTRAR <i>SEP 13 1957</i>			24b. REGISTRAR'S SIGNATURE <i>Marie L. Oberholser</i>			
VS A15 (4) 15M 9/55												

RECEIVED
MURRAY V. A.

SEP 10 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9203

CERTIFICATE OF DEATH

Reg. Dist. No. 09194 ✓

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH b. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 51 days		a. STATE Maryland b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print)		First HAYES	Middle H.	Last FRAZIER	4. DATE OF DEATH September 21
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8/30/15	9. AGE (In years last birthday) 42 yrs.	10. IF UNDER 1 YEAR Months Days Hours 11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chrome Acid Operator		10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Hayes Frazier		14. MOTHER'S MAIDEN NAME Mary Parker		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-10-4345		17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG LEFT, WITH LIVER METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1, 1957 to September 21, 1957. XXXXXX and that death occurred at 9:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Harold R. Johnson</u> M.D. DATE SIGNED PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M. D. Fort Howard, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-57		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	
22d. LOCATION (City, town, or county) Baltimore		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE 9/23/57		24b. REGISTRAR'S SIGNATURE Benson L. Johnson	

Charles R. Law, Mortuary 802-04 Madison Ave., Balto., Md.

BUREAU V. S.

SEP 01 1972

PREGELVIE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09195

9204

CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jacksonville</i>		c. LENGTH OF STAY IN 1b <i>37 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Jarrettsville Pk</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Theodore Edward Gengraef</i>		First <i>Theodore</i>	Middle <i>Edward</i>
4. DATE OF DEATH <i>Sept. 1, 1957</i>		5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>23 August 1880</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Butcher</i>	
11. BIRTHPLACE (State or foreign country) <i>Hippoland 1907 N.Y. W.S.A</i>		12. CITIZEN OF WHA COUNTRY? <i>W.S.A</i>	
13. FATHER'S NAME <i>George W. Gengraef</i>		14. MOTHER'S MAIDEN NAME <i>Sophie Maasch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Daughter Mrs Ohler - same</i>	
17. INFORMANT <i>Daughter Mrs Ohler - same</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Carcinoma of prostate</i> (b) DUE TO <i>Cancer of prostate</i> (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <i>19</i>		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Cockeysville Md</i>		20f. (City or town) (County) (State) <i>Cockeysville Md</i>	
21. I certify that I attended the deceased from <i>Aug 31</i> , 1957, to <i>Sept 1</i> , 1957, that I last saw the deceased alive on <i>Aug 31</i> , 1957, and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Walter T. Kees</i> PHYSICIAN'S NAME (Type) <i>Walter T. Kees</i>		ADDRESS (Street, city or town, state) <i>Cockeysville Md</i> DATE SIGNED <i>9-1-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 9-4-1957</i>		22b. DATE THEREOF <i>9-4-1957</i>	
22c. NAME OF CEMETERY OR Crematory <i>Chestnut Grove</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Co Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Horace F. Burgee</i>		24a. REC'D BY REGISTRAR DATE <i>9-5-57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Ely L. Gravely</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

May 5 1957

ALGAEI V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09195

Item 18 Film 221 10-7-57

9205

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 Evans Ave				d. STREET ADDRESS 19 Evans Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First William	Middle Sunday	Last Gerstmyer	4. DATE OF DEATH	Month Sept. 11, 1957	Day 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 26, 1916	9. AGE (In years at birthday) 40 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Year Min.
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Parts manufac		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert B. Gerstmyer				14. MOTHER'S MAIDEN NAME Elsie Y. Tarbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WWII		17. INFORMANT Marlene Gerstmyer, 19 Evans Ave. Timonium		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154x DUE TO Carcinoma classis INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Rectum onset and death							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February, 1957, to Sept 11 th , 1957, that I last saw the deceased alive on Sept 11 th , 1957, and that death occurred at 3:15 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE M. K. Quinn M.D. 1927 York Rd, Towson, Md.							
PHYSICIAN'S NAME (Type) M. K. QUINN 1927 YORK RD, TIMONIUM, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 14/57		22c. NAME OF CEMETERY OR CREMATORIAL Prospect Hill		22d. LOCATION (City, town, or county) Towson, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, inc. 1050 York Rd. Tow. 4							
ADDRESS				24a. REC'D. BY REGISTRAR DATE SEP 17 1957			
				24b. REGISTRAR'S SIGNATURE H. J. Henrich			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

UREAU V. S.

SEP 18 1957

REGELVÉO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9206

CERTIFICATE OF DEATH

09197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home 5743 Edmondson Avenue		d. STREET ADDRESS 4770 Elison Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	FIRST Lydia	MIDDLE A.	LAST Gessner	4. DATE OF DEATH September 10	Month Year 1957
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1871	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Joseph J. Gessner, Sr.,		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Joseph J. Gessner, 4770 Elison Avenue Address v	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma, generalized INTERVAL BETWEEN ONSET AND DEATH 1 year DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Arteriosclerotic Cardiovascular Disease					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Arteriosclerotic Cardiovascular Disease			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1957 , to Sept. 10, 1957 , that I last saw this deceased alive on Sept. 9, 1957 , and that death occurred at 11:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore DATE SIGNED Sept. 12, 1957 ACTUAL SIGNATURE John F. Schaefer, M.D. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-14-57		22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS		RECD BY REGISTRAR DATE SEP 16 1957	
				24b. REGISTRAR'S SIGNATURE John F. Schaefer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon followers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 15 1957

BUREAU N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09198

9157

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY BALTO.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD		b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDAK		c. LENGTH OF STAY IN 1b 17 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 59 DUNDALK 22		d. STREET ADDRESS DUNKIRK HTS. SHIPPING PL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DUNKIRK HTS. SHIPPING PL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WILLIAM		First JAMES	Middle GODFREY	Lost 9/25/57	4. DATE OF DEATH 9/25/57	Month 9	Day 25	Year 1957	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 10 1910	9. AGE (In years last birthday) 43	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRAFBMAN		10b. KIND OF BUSINESS OR INDUSTRY STEEL MFGR.		11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHA COUNTRY? U.S. AD.			
13. FATHER'S NAME JAMES J. GODFREY		14. MOTHER'S MAIDEN NAME LURENA McGINNIS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 207 01-772		17. INFORMANT MARGARET L. GODFREY - SAME		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Cerebral hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 12 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Hypertensive cardiovascular disease				1/Year.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1 1956 to Sept 23 1957 , that I last saw the deceased alive on Sept 23 1957 , and that death occurred at 925P M. from the causes and on the date stated above		ACTUAL SIGNATURE David H. Andrew		M.D.		ADDRESS (Street, city or town, state) 33 DUNDALK Ave		DATE SIGNED 9/27/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/57		22c. NAME OF CEMETERY OR CREMATORIUM WASHBURN ST. CEM.		22d. LOCATION (City, town, or county) SCRANTON PENNA.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Alberto Luis Rendell, Rendell, M.D.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 30 1957		24b. REGISTRAR'S SIGNATURE Mr. Kelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N.Y.

SEP 30 1957

KELLYVILLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9297

CERTIFICATE OF DEATH

09199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 67 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROY	Middle C	4. DATE OF DEATH September 21 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME George T. Graham		14. MOTHER'S MAIDEN NAME Susan Hamilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO 220-34-5402	17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF THE LUNG WITH METASTASES 1648 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 16, 1957 , to September 21, 1957 , and death occurred at 9:45 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Harold R. Johnson</i>		M.D. Veterans Administration Hospital 9/22/57	
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M. D.		Fort Howard, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-1957	22c. NAME OF CEMETERY OR CREMATORIUM St. James Cemetery
22d. LOCATION (City, town, or county) Dennings, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	24a. REC'D BY REGISTRAR DATE SEP 24 1957
		24b. REGISTRAR'S SIGNATURE <i>Harold G. Johnson</i>	

BUREAU V. 2

SEP 11 1997

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09200
45

Reg. Dist. No.

9208

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Essex	a. STATE	Maryland Balto.
c. LENGTH OF STAY IN lb			b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		17 Pelczar Ave	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Essex 21 Md.
d. STREET ADDRESS		17 Pelczar Ave	e. IS RESIDENCE ON A FARM?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
David			GRISGREN-GREER	Jan. 11-1913	44 yrs.	Sept	4 1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UND. 24 HRS.	
male	W.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		44 yrs.	Months Days	Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	Construction	Tenn.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
John W. Greer	Mary Beckman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	412-18-7440	Ruby Greer	Some

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c)		86 min.
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO		
(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
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ACTUARIAL SIGNATURE <i>Jack Collins</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 9-4-57
EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Remove	22b. DATE THEREOF 9-5-57	22c. NAME OF CEMETERY OR CREMATORIAL Memorial Pk Cemetery	22d. LOCATION (City, town, or county) Tenn.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE A. Christine Brzdzinski	ADDRESS 1407 Eastern Ave.	24a. REC'D BY REGISTRAR SEP 6 1957	24b. REGISTRAR'S SIGNATURE Edith Murphy	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for filing.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1501

GEORGIA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09201
4

9299 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY IN lb About 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XJ Edgemere				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box No. 530 Rt. 10. #19 Zone		d. STREET ADDRESS Box No. 530 Rt. 10. #19 Zone		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print)	First ROY	Middle E.	Last HAINES	4. DATE OF DEATH Sept. 19 1957.	Month Sept.	Day 19	Year 1957.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 13, 1910	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during regular working life, even if retired) Television Repairman		10b. KIND OF BUSINESS OR INDUSTRY 20th Century		11. BIRTHPLACE (State or foreign country) Selinsgrove, Pa.		12. CITIZEN OF WHA COUNTRY? U.S.A.		
13. FATHER'S NAME John W. Haines			14. MOTHER'S MAIDEN NAME Emma L. Stimeling					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, amount of time, if yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Pauline B. Haines		Address Same.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)			<i>Coronary Deterioration</i> <i>Coronary Artery Disease</i>			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 4 yrs.		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour p. m.	Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Elkridge</i>	(County) <i>Elkridge</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>July 1957</i> to <i>Sept. 19, 1957</i> , that I last saw the deceased alive on <i>Sept. 14, 1957</i> , and that death occurred at <i>8:00 P.M.</i> M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. T. Means</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>J. T. Means</i> DATE SIGNED <i>8/21/57</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) CURIAL	22b. DATE THEREOF 9-23-57	22c. NAME OF CEMETERY OR CREMATORIUM MEADOW RIDGE	22d. LOCATION (City, town, or county) ELKRIDGE, MD.	(State) <i>Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lorraine L. G. J. T. Means</i>	ADDRESS <i>9299 Conkling St., Baltimore, Md.</i>	24a. REC'D BY REGISTRAR <i>23 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Lorraine L. G. J. T. Means</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

SEP 22

RECEIVED

REC'D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9210

CERTIFICATE OF DEATH

09202

Reg. Dist. No.

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.			
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2Yrs. 3 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). Baltimore	
3. NAME OF DECEASED (Type or print) Mary		First K.	Middle Hall
4. DATE OF DEATH September / 21 1957		Last Sept 21	Month September
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 1, 1869
9. AGE (In years lost birthday) 88 yr.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At. Home		10b. KIND OF BUSINESS OR INDUSTRY Davie Co. North Carolina	
11. BIRTHPLACE (State or foreign country) Davie Co. North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Shoaf		14. MOTHER'S MAIDEN NAME Camoline Hendricks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Charles Anderson, 106 Cherrydell Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arterio Sclerotic Cardio Vasc. Disease cerebral		(c) Eye	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1957, to Sept 21, 1957 , that I last saw the deceased alive on Sept 10, 1957 , and that death occurred at 7 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Cliff Ratliff Jr. M.D. ADDRESS (Street, city or town, state) 4605 Edmonson Ave DATE SIGNED 9/27/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-57	
22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS Ellsworth Armacost - 4600 Liberty Hghts. Ave.	
24a. REC'D BY REGISTRAR SEP 26 57		24b. REGISTRAR'S SIGNATURE W. L. Gedrich	

RECEIVED
BUREAU N.Y.

SEP 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. John's		c. LENGTH OF STAY IN 1b 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.		d. STREET ADDRESS 4419 Marble Hall Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home—Reister Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First NANNIE	Middle M.	Last HARN	4. DATE OF DEATH Sept. 12,	Month 1957	Doy Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1869		9. AGE (in years last birthday) 88 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Henry Becht		14. MOTHER'S MAIDEN NAME Louisa					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. no		17. INFORMANT Mr. John E. Harn - 4646 Marble Hall Rd. #12		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				CEREBRAL THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 12 DAYS	
				GENERALIZED ARTERIOSCLEROSIS		YEARS	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 31, 1957, to SEPT. 12, 1957, that I last saw the deceased alive on SEPT. 12, 1957, and that death occurred at 912 M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE ARTHUR KIRK				M.D. 1532 HAVENWOOD ROAD BALTIMORE-18, MD			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/57		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery		22d. LOCATION (City, town, or county) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. M. J. Sickner & Sons - Bachman		ADDRESS		24a. RECD BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Hubel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

SEP 17 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09204

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. LENGTH OF STAY IN 1b <i>2 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shawau Rd</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>	
d. STREET ADDRESS <i>Shawau Rd</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Dora Abigail Harrell</i>		First	Middle
		Last	4. DATE OF DEATH <i>Sept 9 1957</i>
5. SEX <i>Female</i>		6. COLOR OF HAIR <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>13 Oct 1875</i>		9. AGE (in years last birthday) yrs. <i>81</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Sona Thair Nester</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Dorrell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Stella Nester</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decomposition</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>arterio sclerotic cardiovascular disease 17 yrs</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 1957</i> to <i>9 Sept 57</i> , that I last saw the deceased alive on <i>6 Sept 1957</i> , and that death occurred at <i>1A</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Halder T. Kees</i>		ADDRESS (Street, city or town, state) <i>Cockeysville Md 21030</i>	
PHYSICIAN'S NAME (Type) <i>Walter T Kees</i>		DATE SIGNED <i>Sept 5 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>9-17-57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>New Dublin Presbyterian</i>		22d. LOCATION (City, town, or county) (State) <i>Dublin Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. Scott Brooks, 1622 York Rd, Towson, Md</i>		ADDRESS <i>1622 York Rd, Towson, Md</i>	
24a. REC'D BY REGISTRAR <i>SEP 11 57</i>		24b. REGISTRAR'S SIGNATURE <i>Asst. Coroner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WIREAU V. S.

NO. 1 - 1957

DEGELEVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09205
44

9213

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN Tb 84 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERNA PARK				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 112 AVONDALE CIRCLE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First THOMAS	Middle A	Last HARRIS	4. DATE OF DEATH SEPTEMBER 19 1957	Month SEPTEMBER	Day 19	Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 24, 1913	9. AGE (In years lost birthday) 44 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANK E. HARRIS		14. MOTHER'S MAIDEN NAME CHARLOTTE KRAM						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-11 183-03-8919		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL METASTASIS							1 WEEK	
163X DUE TO CARCINOMA OF THE LUNG							1 YEAR	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from JUNE 27, 1957 , to SEPT. 19, 1957 , and took care of the deceased daily and that death occurred at 1:00 P.M. from the causes and on the date stated above.							ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <i>Roland Ponce de Leon</i>		M.D. VAH, FORT HOWARD, MARYLAND					9-19-57	
PHYSICIAN'S NAME (Type) ROLAND PONCE de LEON								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-23-57		22c. NAME OF CEMETERY OR CREMATORIUM ANNAPOLIS NATIONAL CEMETERY ANNAPOLIS, MARYLAND		22d LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE JOHN TAYLOR & SONS Annapolis, Maryland.		ADDRESS 147 Duke of Gloucester St.: Annapolis, Maryland.		24a. REC'D BY REGISTRAR DATE 9/23/57		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farber</i>		

BUREAU V. S

SEP 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9167

CERTIFICATE OF DEATH

09206

Reg. Dist. No.

46

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	a. STATE Maryland b. COUNTY Baltimore					
Halethorpe		6 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
4417 Linden Ave.,		4417 Linden Ave.,						
3. NAME OF DECEASED (Type or print)	First Mattie	Middle Elizabeth	Last Harvey	4. DATE OF DEATH Sept. 1,	Month 1957.	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 20 ^m 1877	8. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John D. Childs			14. MOTHER'S MAIDEN NAME Sophronia Jones					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Kenneth J. Baumann	Address 4417 Linden Ave.				(27)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Cerebral and right popliteal thromb; almt 3 weeks</i> DUE TO (c) <i>Atherosclerotic Cardio Vascular Disease</i> years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>atrophic arthritis & lumbosacrosis</i>								
19. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. TIME OF INJURY Hour a. m. p. m.	Month 19	20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 4335 Park Heights Ave.	(County)	(State)		
21. I certify that I attended the deceased from <i>April</i> , 1950, to <i>Sept. 1</i> , 1957, that I last saw the deceased alive on <i>Sept. 1</i> , 1957, and that death occurred at <i>2140 Park Heights Ave.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE Louis R. Maser M.D.		ADDRESS (Street, city or town, state) <i>4335 Park Heights Ave.</i> DATE SIGNED <i>9/3/57</i>						
PHYSICIAN'S NAME (Type) Louis R. Maser M.D.		22d. LOCATION (City, town, or county) Pikesville, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-4-1957	22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge	22d. LOCATION (City, town, or county) Pikesville, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard Strong</i>		ADDRESS <i>3007 W North Ave.</i>	24a. REC'D BY REGISTRAR SEP 4 1957	24b. REGISTRAR'S SIGNATURE <i>John G. Kupper</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

PRINTED IN U.S.A.

SEP 4 1957

KELGEVÉ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09207

9214 CERTIFICATE OF DEATH

Reg. Dist. No. 44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) RUSSELL		First I.	Middle HARVEY
4. DATE OF DEATH September 22 1957		Month September	Day 22
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9/15/22		9. AGE (In years last birthday) 35 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk		10b. KIND OF BUSINESS OR INDUSTRY Automobile Supply	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Samuel Harvey		14. MOTHER'S MAIDEN NAME Aline Dorsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes		16. SOCIAL SECURITY NO. W.II 218-12-2189	17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA			
DUE TO ARTERIOLAR NEPHROSCLEROSIS AND CHRONIC GLOMERULONEPHRITIS			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 9, 1957, to September 22, 1957, and that death occurred at 3:10 PM, from the causes and on the date stated above, and that death occurred at 3:10 PM , from the causes and on the date stated above, ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE CHIEN WEI LAN		DATE SIGNED 9/23/57	
PHYSICIAN'S NAME (TYPE) Charles R. Law		M.D. Veterans Administration Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-57	22c. NAME OF CEMETERY OR CREMATORIUM Bush Park Cemetery
22d. LOCATION (City, town, or county) Cooksville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS	24b. REGISTRAR'S SIGNATURE Dawson L. Farber
		REG'D BY REGISTRAR SFP	DATE 9-27-57

BUREAU V.

CEP 11 1957

REGELVÉO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9215

CERTIFICATE OF DEATH

0920838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural	c. LENGTH OF STAY IN lb 35Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 602 Murdock Road	d. STREET ADDRESS 602 Murdock road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary Elizabeth Heim	First	Middle	Last		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1875		
9. AGE (In years lost birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---			
11. BIRTHPLACE (State or foreign country) Prince George's City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Ireland		14. MOTHER'S MAIDEN NAME Martha ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none			
17. INFORMANT Warner D. Heine, Jr. 916 Litchfield Road		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Towson	(County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE M. K. Dunn M.D.				ADDRESS (Street, city or town, state) 1927 York Rd. Towson	DATE SIGNED 8/16/57
22a. BURIAL, CREMATION, BEMVAEG (Specify) 9/17/57		22b. DATE THEREOF 9/17/57		22c. NAME OF CEMETERY OR CREMATORIUM Govans Presbyterian Cem. Baltimore, Maryland	
22d. LOCATION (City, town, or county) (State)		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mabel Gray	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran -3000		ADDRESS Baltimore Street		SEP 18 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 10 1957

MAIL BOX

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9216 CERTIFICATE OF DEATH

09209 44
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN lb 39 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1831 N. Linden Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ARMINIUS	Middle NONE	Last HENDERSON	4. DATE OF DEATH	Month September	Day 21	Year 1957
S. SEX MALE	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1988	9. AGE (in years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) Richmond, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred				14. MOTHER'S MAIDEN NAME Rose Rich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW I 220-05-0971		17. INFORMANT Clin Rec. Vet Adm Hosp. Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYELOMA				INTERVAL BETWEEN ONSET AND DEATH 2 Months			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 13 1957 to Sept 21 1957 and that death occurred at 12:20 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fort Howard, Maryland DATE SIGNED Sept 24 1957							
ACTUAL SIGNATURE George Vash M.D. Veterans Administration Hospital							
PHYSICIAN'S NAME (Type) DR. George Vash		Fort Howard, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-57		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National		22d. LOCATION (City, town, or county) (State) 5501 Frederick Rd Balto Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Jackson Funeral Home				ADDRESS 916 Penna. #1		24a. REC'D BY REGISTRAR SEP 24 1957	
						24b. REGISTRAR'S SIGNATURE Davidson Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death: Page 1 by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician, signed by the funeral director. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

SEP 6 1967

KIEGEVIE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9217

CERTIFICATE OF DEATH

0921038
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
f. STREET ADDRESS 1609 E. 29th Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret		First Matilda	Middle Hickman
4. DATE OF DEATH September 7 1957	Month Sept.	Day 7	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/2/1881
9. AGE (in years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
13. FATHER'S NAME Thomas Mooney	14. MOTHER'S MAIDEN NAME Helen Murphy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 225-32-2539	17. INFORMANT HOSP. RECORDS	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 Months	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1955</u> to <u>September 1957</u> that I last saw the deceased alive on <u>September 1957</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE CHARLES F. DONNELL PHYSICIAN'S NAME (Type) Charles F. Donnell MD	ADDRESS (Street, city or town, state) CHARLES F. DONNELL 7501 YORK RD 97157 DATE SIGNED 9/7/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/11/57	22c. NAME OF CEMETERY OR CREMATORIUM Forest Cliff	22d. LOCATION (City, town, or county) Anchorage
23. FUNERAL DIRECTOR'S SIGNATURE MacNutt & Son	ADDRESS S	24a. REC'D BY REGISTRAR SEP 11 1957	24b. REGISTRAR'S SIGNATURE Mabel Gray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
LIBRARY
UNIVERSITY OF TORONTO LIBRARIES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09211 33

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		Rosewood St. Training School a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)		o. STATE Maryland		b. COUNTY City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Owings Mills, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore 23, Maryland							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Rosewood State Training School				d. STREET ADDRESS		1013 West Fayette Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Lelia	Middle	Last Higgins	4. DATE OF DEATH	Month 9	Doy 3	Year 19 57							
5. SEX		6. COLOR OR RACE F Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/43		9. AGE (In years last birthday) 14 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Al Higgins			14. MOTHER'S MAIDEN NAME Belle McDowell (deceased)			Address <i>2117 Loma</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT Rosewood Records			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Status epilepticus</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>#3.1</i> (b) <i>Microcephaly</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH since birth			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from <u>10/15/56</u> , 19, to <u>9/3/57</u> , 19, that I last saw the deceased alive on <u>9/3/57</u> , 19, and that death occurred at <u>8:05 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Harry G. Butler</i> M.D.													ADDRESS (Street, city or town, state) <i>Baltimore, Md.</i>		DATE SIGNED
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.			Rosewood Training School, Owings Mills, Md.			22a. BURIAL-CREMATION OR REMOVAL (Specify) <i>9/4/57</i>			22b. DATE THEREOF <i>9/4/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Baltimore Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank D. Newell</i>			ADDRESS <i>1013 West Fayette Street</i>			24a. REC'D BY REGISTRAR DATE <i>SEP 6 1957</i>			24b. REGISTRAR'S SIGNATURE <i>Mary Elmer</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

CC 6 1957

EXCELSIOR LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9219

CERTIFICATE OF DEATH

09212 35
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Penns.</i>		b. COUNTY <i>York</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Freeland</i>		c. LENGTH OF STAY IN 1b <i>3 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Freedom.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Middle town Rd.</i>		d. STREET ADDRESS <i>Tolna Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>John C. Hoffman</i>		First	Middle	Last	4. DATE OF DEATH <i>Sept. 10, 1957</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 28 1873</i>	9. AGE (in years (month-birthday) yrs.) <i>84</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm.</i>		11. BIRTHPLACE (State or foreign country) <i>Glen Rock, Pa. RD 2, U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Citizen of U.S.A.</i>		
13. FATHER'S NAME <i>Cincinnati Hoffman</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Fillmore</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>17. INFORMANT Mrs. Wilbur Deeny, New Freedom, Pa.</i>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterosclerotic Cardio Vascular disease</i>								
INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs.</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Sept. 9, 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Shrewsbury, Pa.</i>		20f. (City or town) (County) <i>Shrewsbury, Pa.</i>		(State) <i>Pa.</i>
21. I certify that I attended the deceased from <i>Sept. 1, 1957</i> to <i>Sept. 9, 1957</i> , that I last saw the deceased alive on <i>Sept. 9, 1957</i> , and that death occurred at <i>12:30 A.M.</i> from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <i>Shrewsbury, Pa.</i>								
DATE SIGNED <i>9-11-57</i>								
ACTUAL SIGNATURE <i>Paul D. Shaub</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>Paul D. Shaub, M.D.</i>		Shrewsbury, Pa.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept. 13, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Elizabeth Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Glen Rock, Penns.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul D. Shaub, New Freedom, Pa.</i>		ADDRESS <i>100 Main Street, New Freedom, Pa.</i>		24a. REC'D BY REGISTRAR DATE <i>9/13/57</i>		24b. REGISTRAR'S SIGNATURE <i>Chester & Franklin</i>		

BUREAU V. S.

SEP 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9220

CERTIFICATE OF DEATH

09213
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Con. Home		d. STREET ADDRESS 207 Rock Glen Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Rezin M. Hood	Middle	Last
S. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1867
	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years and birthday) 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis F. Hood		14. MOTHER'S MAIDEN NAME Martha Sanborn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT	
		Mrs. Virginia G. Hood, 809 Woodington Rd	
Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE		5 MONTHS	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) CEREBRAL ARTERIAL SCLEROSIS			
DUE TO (c) GENERAL ARTERIOSCLEROSIS.....		1-2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) o	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APR. 25, 1957, to SEPT. 19, 1957, that I last saw the deceased alive on SEPT. 10, 1957, and that death occurred at 1:30PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>S. Lloyd Johnson</i>		M.D.	
PHYSICIAN'S NAME (Type) S. LLOYD JOHNSON M.D.		6348 FREDERICK ROAD, CATONSVILLE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 21/57	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Loudon Park		22d. LOCATION (City, town, or county) (State) Balto. 29	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave		24a. REC'D BY REGISTRAR DATE SEP 23 '57	
		24b. REGISTRAR'S SIGNATURE <i>Reed</i>	

RECEIVED
MAY 22 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09214

9221

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY		Baltimore Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
				a. STATE	b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		PARKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		3013 Edgewood Ave		d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		FIRST	MIDDLE	LAST	4. DATE OF DEATH		
Charles				HORNE	Sept 9 1951		
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
M	W			MAY 5 - 1890	67		
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Carpenter		Steel Mill		Scotland		USA	
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME					
James Horne		Agnes Morris					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
(If yes, give war or dates of service)		213-07-651 Mrs Chas Horne		3013 Edgewood Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Cedam's Stokes Syndrome.				INTERVAL BETWEEN ONSET AND DEATH Sudden.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thromboses.				"	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Atherosclerosis				5 Yrs.	
b)							
c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
19		Not while at work		9005 Harford Rd.			
21. I certify that I attended the deceased from _____		to _____		that I last saw the deceased			
alive on _____		1951		and that death occurred at 7:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		M.D.		9005 Harford Rd.		DATE SIGNED 2/10/57	
PHYSICIAN'S NAME (Type)		FRANK T. KASIK JR BALTO 14 MD					
22a. FUNERAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town or county)	
POCAH		12-1951		St John. Lut. Church		Parkville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Chas F. Evans & Son		8802 Harford Rd.		SEP 2 1951		John M. Bacon	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 16 1957

BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09215

44

9222

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/cremation permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 919 S. Sharp Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First RUFUS	Middle NONE	Last HORTON	4. DATE OF DEATH	Month September	Day 4	Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 80	IF UNDER 24 HRS Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Steel Company		11. BIRTHPLACE (State or foreign country) Apex, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Perry Horton			14. MOTHER'S MAIDEN NAME Harriett Burt					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO Spanish American Unknown		17. INFORMANT Clin Rec. Vet. Adm. Hosp. Ft. Howard, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONTA, BILATERAL		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN						
DUE TO 181X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. RIGHT KIDNEY DUE TO OBSTRUCTION OF THE RIGHT URETHRAL ORIFICE DUE TO CARCINOMA OF URINARY BLADDER		RIGHT KIDNEY DUE TO OBSTRUCTION OF THE RIGHT URETHRAL ORIFICE DUE TO CARCINOMA OF URINARY BLADDER 6 MONTHS						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. p. m.	Month Aug	Doy 19	Year 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH Ft. Howard, Md.	20f. (City or town) Ft. Howard	(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from August 14, 19 57 , to September 4, 19 57 , and that death occurred at 7:00 PM from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Chien Wei Jan							DATE SIGNED 9/5/57	
ACTUAL SIGNATURE	M.D. VAH Ft. Howard, Md.							
PHYSICIAN'S NAME (Type)	Chien Wei Jan, M.D.						9/5/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/13/57	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National			22d. LOCATION (City, town, or county) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Isafah L. Brown & Son, 123 W. Montgomery St., Balt.		ADDRESS Isafah L. Brown & Son, 123 W. Montgomery St., Balt.		24a. REC'D BY REGISTRAR 9/11/57		24b. REGISTRAR'S SIGNATURE Isafah L. Brown		

RECEIVED

SEP 13 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9223

CERTIFICATE OF DEATH

09216

Reg. Dist. No.

PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

368 Old Philadelphia Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

x 2

d. STREET ADDRESS

368 Old Philadelphia Rodd

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First George H.

Middle

Last Howe

4. DATE
OF
DEATH

Sept

Month 4 Day 1957 Year

5. SEX

male

6. COLOR OR RACE white

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Aug. 15, 1872

9. AGE (In years
last birthday)
85 yrs.IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Brickyard Worker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Maine

USA

13. FATHER'S NAME

James Howe

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

218-09-1773A Mrs. Wilhelmina Howe, 368 Old Phila Rd

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

422.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Cerebral apoplexy

INTERVAL BETWEEN
ONSET AND DEATH

1 day

Arteriosclerotic Cardiovascular

5 yrs

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

Month

Day

Year

Hour

o. m.

19

p. m.

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Jan 1, 1957, to Sept 4, 1957, that I last saw the deceased alive on Sept 4, 1957, and that death occurred at 3 A. M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

George M. Baumgardner M.D.

Baltimore Md

9/4/57

PHYSICIAN'S
NAME (Type)

George M. Baumgardner

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 9/7/1957

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Stemmers Run, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Leonard J. Ruck

ADDRESS

5305 Harford Road #14

24a. REC'D BY REGISTRAR

DATE

9/4/57

24b. REGISTRAR'S SIGNATURE

Edith Bentley

S. V. FEUREAU

1957 à D.

EGEIVEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09217

9168

CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5544 Selma Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
3. NAME OF DECEASED (Type or print) Doris A. Hutchens		First	Middle
4. DATE OF DEATH Sept., 20	Month	Day	Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Louis Schlickenmaier		14. MOTHER'S MAIDEN NAME Etta Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220.24.7165	17. INFORMANT Address D. Prichard Hutchens 5544 Selma Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MYOCARDIAL INFARCTION BRONCHIAL PNEUMONIA RHEUMATIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) Elkridge, Md.	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Elkridge, Md.
21. I certify that I attended the deceased from Sept., 1950 , to 19 SEPT., 1957 , that I last saw the deceased alive on 19 SEPT., 1957 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elkridge, Md. DATE SIGNED George E. Groleau, M.D.			
ACTUAL SIGNATURE George E. Groleau		PHYSICIAN'S NAME (Type) G.E. Groleau	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/57	22c. NAME OF CEMETERY OR CREMATORIAL Meadow Ridge
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		ADDRESS 6411 Windsor Mill Rd.	22d. LOCATION (City, town, or county) Elkridge, Md.
		24a. REC'D BY REGISTRAR SEP 23 1957	24b. REGISTRAR'S SIGNATURE Dr. George E. Groleau

PUREAU Y. S

SEP 28 1957

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9158 CERTIFICATE OF DEATH

09218

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY BALTO.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M.D.		b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		d. STREET ADDRESS 7434 HORABIRD AVE.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7434 HORABIRD AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JOHN WM. ISAAC		First	Middle	Last	4. DATE OF DEATH SEPT. 13 1957	Month	Day	Year	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 4-1895	9. AGE (in years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME JOHN H. ISAAC		14. MOTHER'S MAIDEN NAME LULA SEWARD						Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral anoxia.				INTERVAL BETWEEN ONSET AND DEATH 1 day			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) metastatic carcinoma				5 mos.			
(c) DUE TO		Carcinoma of Pancreas				6+ mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) OAK LAWN		20f. (City or town) BALTO.		(County)	(State)
21. I certify that I attended the deceased from _____ May _____, 1957, to Sept 13, 1957 that I last saw the deceased alive on _____ 9/13, 1957, and that death occurred at 11:45 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) M.D. 434 Eastern Ave. Essex, MD		DATE SIGNED 9/17/57	
ACTUAL SIGNATURE J. PLATT									
PHYSICIAN'S NAME (Type) J. PLATT, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL SEPT. 17-1957		22b. DATE THEREOF SEPT. 17-1957		22c. NAME OF CEMETERY OR CREMATORIAL OAK LAWN		22d. LOCATION (City, town, or county) BALTO.		(State) M.D.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Kennedy, Essex, MD,		ADDRESS SEP. 21, 1957		24a. REC'D BY REGISTRAR DATE SEP 18 1957		24b. REGISTRAR'S SIGNATURE John J. Kelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU Y.

SEP 11 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9224 CERTIFICATE OF DEATH

09219
Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <i>Balto</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Balto</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ARMAGH VILLAGE</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ARMAGH VILLAGE</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>210 N TYRONE Rd</i>	e. STREET ADDRESS <i>210 N TYRONE Rd</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Estella Olivine Jackson</i>	First <i>E</i>	Middle <i>S</i>	Last <i>Jackson</i>	
4. DATE OF DEATH <i>Sept 20</i>	Month <i>Sept</i>	Day <i>20</i>	Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 27 1883</i>	
9. AGE (in years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Balto Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Richard Olivine</i>	14. MOTHER'S MAIDEN NAME <i>Louisa Lang</i>	Address <i>Andrew Jackson Dame</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Andrew Jackson Dame</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Decompressive CardioVascular Disease</i> DUE TO 445X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension</i> (c) <i>Arteriosclerosis</i>	INTERVAL BETWEEN ONSET AND DEATH
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. <i>6805 York Rd.</i>	(County) <i>Baltimore</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Aug 10</i> , 1950 to <i>Sept 20</i> , 1957, that I last saw the deceased alive on <i>Sept 20</i> , 1957, and the death occurred at <i>10:30 AM</i> , from the causes and on the date stated above.	ADDRESS (Street, city, or town, state) <i>6805 York Rd.</i>			DATE SIGNED <i>9-20-57</i>
ACTUAL SIGNATURE <i>Laurence C. Post</i>	PHYSICIAN'S NAME (Type) <i>LAURENCE C. Post</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Sept 23 57 LORRAINE</i>	22b. DATE THEREOF <i>Sept 23 57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>LORRAINE</i>	22d. LOCATION (City, town, or county) <i>Woodlawn</i>	(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. J. Jenkins Sons Co 4905 York Rd</i>	ADDRESS <i>4905 York Rd</i>	24a. REC'D. BY REGISTRAR DATE <i>Sept 23 57</i>	24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09220

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		LUTHERVILLE		c. LENGTH OF STAY IN lb		d. STATE MD. b. COUNTY BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		1421 BELLONA AVE.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X- LUTHERVILLE			
3. NAME OF DECEASED (Type or print)		First SARAH	Middle MEDORA	Last JEFFERSON	4. DATE OF DEATH	Month SEPT	Day 22	Year 1957	
5. SEX F		6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 12-17-83	10. AGE (in years less birthday) 74 yrs.	11. IF UNDER 1 YEAR Months	12. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) GA.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ALBERT WATTS		14. MOTHER'S MAIDEN NAME Sarah ?							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. —		17. INFORMANT REV. MATTHEW JEFFERSON, SAME		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 12 YRS.									
482.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE William A. Pillsbury		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/22/57	
EXAMINER'S NAME (Type) William A. Pillsbury									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-57		22c. NAME OF CEMETERY OR CREMATORIAL Balto. National		22d. LOCATION (City, town, or county) 5501 Frederick Ave.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Jackson Funeral Home		ADDRESS 916 Pennsylvania		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
				DATE SEP 24 '57		OCT 1957			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

ELAU V. S

SEP

REGELIV E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09221

Reg. Dist. No.

3159

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, file ex-
 certifiable, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
 forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,
 or removal.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Armagh Village				Armagh Village		107 Armagh Drive		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		107 Armagh Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Joseph	Middle V.	Last Jerardi	4. DATE OF DEATH	Month September	Day 26	Year 1957
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 50 yrs.	IF UNDER 24 HRS. Hours Min.	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 7, 1906	50 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Physician			Medical		Baltimore, Md.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME					
Pasquale Jerardi			Catherine Majane					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
				Mrs. Joseph V. Jerardi		107 Armagh Drive		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Sudden</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Charles F.O'Donnell</u> DATE SIGNED <u>9/17/17</u>								
EXAMINER'S NAME (Type) <u>Charles F.O'Donnell</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/57	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. W. Meads</u> DATE <u>9/30/57</u> REG. NO. <u>161143</u>								
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE						

EDMUND V. S

SEP

EDMUND V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9226 CERTIFICATE OF DEATH

Reg. Dist. No. 09222

1. PLACE OF DEATH a. COUNTY Howard Baltimore Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Howard Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b 52	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Melrose Ave.		d. STREET ADDRESS 16 Melrose Ave.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida May Johnson	First Ida	Middle May	Last Johnson
4. DATE OF DEATH Sept. 7, 1957	Month Sept.	Day 7	Year 1957
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Prince Geo. Co. Md.
12 CITIZEN OF WHAT COUNTRY? Prince Geo. Co. Md.			
13. FATHER'S NAME Thomas Johnson		14. MOTHER'S MAIDEN NAME Mariah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 111-11-1111	17. INFORMANT Eugene Jackson	Address 520 N. Arlington Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 22 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Hypertensive Arterio-sclerosis		?	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Baltimore (County) Md. (State) Md.
21. I certify that I attended the deceased from 8/17/57 , 19, to 9/7/57 , 19, that I last saw the deceased alive on 9/7/57 , 19, and that death occurred at 3:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Winters Lane, Baltimore, Md. DATE SIGNED 9/7/57			
ACTUAL SIGNATURE C.F. Maloney M.D.			
PHYSICIAN'S NAME (Type) C.F. Maloney M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 11, 57	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn Cem.	22d. LOCATION (City, town, or county) Baltimore Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams		ADDRESS 3229 Schoolhouse St.	24a. REC'D BY REGISTRAR Oct. 11, 57 DATE
24b. REGISTRAR'S SIGNATURE Oct. 11, 57			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. GOVERNMENT
PRINTING OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9227 CERTIFICATE OF DEATH

09223
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore 19 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE as b. COUNTY in	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anacostia Pt		c. LENGTH OF STAY IN lb 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2529 - Sycamore Ave				d. STREET ADDRESS # 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ANNIE	Middle JONES	4. DATE OF DEATH Sept. 28	Month 1957
5. SEX Fem		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1880	9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Blackstone Va.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Annie (unknown)		12. CITIZEN OF WHAT COUNTRY? # 19	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Rebecca Stein - 2505 Sycamore Av	
no.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension		DUE TO arteriosclerotic heart disease -		INTERVAL BETWEEN ONSET AND DEATH 4 years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 19, 1957, to Sept 28, 1957, that I last saw the deceased alive on Sept 4, 1957, and that death occurred at 8 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 6908 N. St Rd. Sept 28/57	
ACTUAL SIGNATURE Louis N. Toffin		M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) LOUIS N. Toffin					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-1-57		22c. NAME OF CEMETERY OR CREMATORIUM Mt Calvary	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE 9/30/57	
Samuel W. Sullivan Jr.		Baltimore		24b. REGISTRAR'S SIGNATURE Lorraine L. Green	

RECEIVED
BUREAU X

OCT 1 1957

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9228

CERTIFICATE OF DEATH

09224 44

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN 1b

9 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Veterans Administration Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

2321 E. Lafayette Ave.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
FREDERICKMiddle
(NMI)Last
KEELER4. DATE
OF
DEATH

September 21

Year
19 57

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Dec. 5, 1874

9. AGE (In years
last birthday)
82 yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Engineering

10b. KIND OF BUSINESS OR INDUSTRY

City of New York

11. BIRTHPLACE (State or foreign country)

Connecticut

12. CITIZEN OF WHA COUNTRY?

U.S.A.

13. FATHER'S NAME

George J. Keeler

14. MOTHER'S MAIDEN NAME

Josephine E. Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

YES

(If yes, give war or dates of service)

SAW

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

Clin/Rec.Vets.Admin.Hospital,Ft.Howard, Md.

Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CEREBRAL VASCULAR ACCIDENT

INTERVAL BETWEEN
ONSET AND DEATH
UNKNOWN

221 X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

CEREBRAL ARTERIOSCLEROSIS

UNKNOWN

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)

21. I certify that I attended the deceased from Sept. 12, 1957, to Sept. 21, 1957, and that death occurred at 11:15 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type) HAROLD R. JOHNSON

Fort, Howard, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM
Burial 9/25/57 Taylorsville Church22d. LOCATION (City, town, or county)
Md. Airy (State) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

Wm Cook-Blightone, 6009 Hayford Rd. SEP 27 1957 Harold R. Johnson

BUREAU V. S.

CCP NO 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9229

CERTIFICATE OF DEATH

09225

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then, please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Catonsville	c. LENGTH OF STAY IN lb	a. STATE	Maryland
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Spring Grove State Hosp.	d. STREET ADDRESS	b. COUNTY	
3. NAME OF DECEASED (Type or print)		First: Bertie Middle: O	Keener	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
4. DATE OF DEATH		Month: Sept. Day: 3 Year: 1957	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday) yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
			11-21-1895	61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S-MAIDEN NAME		12. CITIZEN OF WHA' COUNTRY?	
John Mc Allister		Bertie Speed		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Records: Spring Grove State Hospital Address:	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arteriosclerotic cardiovascular disease			
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Arteriosclerosis, generalized and severe			
(c) DUE TO Diabetes mellitus					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 29, 1957, to Sept. 3, 1957, that I last saw the deceased alive on Sept. 3, 1957, and that death occurred at 3:35 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE: Stella Wachsler M.D. Spring Grove State Hosp. 3-57 PHYSICIAN'S NAME (Type): Stella Wachsler, M.D.			
22a. BURIAL, CREMATION, OR REMOVAL (SOLAR)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn	
Burke's Funeral Home 3637 Falls Rd		Sep 6-1957		22d. LOCATION (City, town, or county) Baltimore Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 4 '57	
Burke's Funeral Home 3637 Falls Rd				24b. REGISTRAR'S SIGNATURE Lee L. Finch	

RECEIVED
BUREAU V. S.

SEP 5 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09226 3

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 File #220 2-19-57 et

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dwingsville</i>		c. LENGTH OF STAY IN 1b <i>20 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>409 W. 21st Street</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Rosewood State Training School</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>BETTY LOUISE KELBAUGH</i>		First	Middle	Last	4. DATE OF DEATH <i>Sept 13 1957</i>	Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Jan 27, 1928</i>	9. AGE (In years last birthday) <i>29 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>W. I. C.</i>		
13. FATHER'S NAME <i>Stanley W. Kelbaugh</i>		14. MOTHER'S MAIDEN NAME <i>Goldie A. Sullivan</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>728-72-728</i>		17. INFORMANT <i>728 Goldie A. Kelbaugh</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>253.3</i>		DUE TO <i>Epilepsy</i>				INTERVAL BETWEEN ONSET AND DEATH <i>26-720</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>		DUE TO <i>(c)</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>No.</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None - Found dead in play room.</i>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>none</i> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTING SIGNATURE <i>D. D. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) <i>D. D. Caples, M.D.</i>		DATE <i>9-14-67</i>						
22a. BURIAL, CREMATION, ANIMAL SPECIES <i>Burial</i>		22b. DATE THEREOF <i>10/18/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Peters</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Burgee Funeral Home</i>		ADDRESS <i>1231 Falls Road</i>		24a. REC'D BY REGISTRAR <i>Horace F. Burgee</i>		24b. REGISTRAR'S SIGNATURE <i>Maryoline</i>		
5. A1 5M 9/55								

BUREAU V. S.

SEP 16 1974

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9160 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK				c. LENGTH OF STAY IN lb 5 YRS.																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7505 SOUTH BEND ROAD				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK																	
f. STREET ADDRESS 7505 SOUTH BEND Rd				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) WALTER EDWARD		First	Middle	Last	4. DATE OF DEATH 9-29-	Month	Day	Year													
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 12 1904		9. AGE (In years last birthday) 53 yrs.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY STEEL STRAPPING		11. BIRTHPLACE (State or foreign country) PENNSA		12. CITIZEN OF WHAT COUNTRY? U. S. A.															
13. FATHER'S NAME BENJ. I KELLER		14. MOTHER'S MAIDEN NAME LOUISE PICKLE		Address BLANCHE M. KELLER — SAME																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-10-2163		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH 20 min															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Colonial Occlusion DUE TO 20.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Colonial Occlusion (c)																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.																					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) DORSEY, MD		(County) Md		(State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> JACK COLLINS									22. ACTUAL SIGNATURE JACK COLLINS							M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-1-57			
EXAMINER'S NAME (Type) JACK COLLINS									23. FUNERAL DIRECTOR'S SIGNATURE Walter Burke Bradley, Dundalk, Md							ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
24a. BURIAL, CREMATION, REMOVED (Specify) BURIAL									24b. DATE THEREOF 10/2/57							24c. NAME OF CEMETERY OR CREMATORIAL MEADOWKNOCE MEM		24d. LOCATION (City, town, or county) DORSEY, MD		(State)	
25. FUNERAL DIRECTOR'S SIGNATURE Walter Burke Bradley, Dundalk, Md									ADDRESS 10012							26a. REG'D BY REGISTRAR 1957		26b. REGISTRAR'S SIGNATURE Tom Kelly			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
MAY 20 1981

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9231 CERTIFICATE OF DEATH

09228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 Westowne Place		d. STREET ADDRESS 118 Westowne Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Leo	Last Knight
4. DATE OF DEATH	Month Sept.	Day 17	Year 1957
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1912
9. AGE (In years last birthday) 45 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug Store	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank L. Knight		14. MOTHER'S MAIDEN NAME Mary J. Norton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. Catherine Dye		Address 4447 Old Fred. Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 120.1 DUE TO Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH c			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arterios clausis C. V. Disease (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 1957, to Sept. 17 , 1957, that I last saw the deceased alive on Sept. 17 , 1957, and that death occurred at 1 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4508 Edmondson Village DATE SIGNED ACTUAL SIGNATURE <i>D. C. MacLaughlin</i> PHYSICIAN'S NAME (Type) D. C. MacLaughlin, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-20-57	22c. NAME OF CEMETERY OR CREMATORIUM Cathedral Gem.	22d. LOCATION (City, town, or county) Baltimore (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home		ADDRESS Catonsville Md.	24a. REC'D BY REGISTRAR DATE SEP 24 57
			24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SUREAU V. S

SEP 14 1987

NEGATIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09229

44

Reg. Dist. No.

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Baltimore			MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard	c. LENGTH OF STAY IN lb 18 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital	d. STREET ADDRESS 2009 Englewood Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GEORGE	First GEORGE	Middle M.	Last KOEHNLIN	4. DATE OF DEATH September 17 1957	Month September	Day 17	Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1892	9. AGE (In years, months, birthday) 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer	10b. KIND OF BUSINESS OR INDUSTRY Police	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME William Koehnlein			14. MOTHER'S MAIDEN NAME Sophie Rahling						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. WW I 216-28-2442		17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. BRONCHIECTASIS (b) DUE TO 49/1X (c)								INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardiovascular Disease (2) Emphysema								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o.m. p.m. VA	Month 19	Doy 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VAH, FORT HOWARD, MARYLAND	(County)	(State)	
21. I certify that I attended the deceased from August 30 1957 to September 17 1957 and that death occurred at 12:00 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) XXXXXX XXXXX XXXXX XXXXX M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 9/17/57									
ACTUAL SIGNATURE J. Freeman									
PATIENT'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-20-57	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery			22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE M. J. Tickner & Sons, Inc., North & Penna. Aves. Baltimore, Maryland			ADDRESS Maryland			24a. REC'D. BY REGISTRAR SEP 18 1957	24b. REGISTRAR'S SIGNATURE Hudson L. Parker		

BUREAU V. S.
REGISTRY

SEP 19 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09230

Reg. Dist. No. 32

9233

DEPUTY MEDICAL EXAMINER: This certificate should be executed within **1 hour** after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give **Pages 1, 2, and 3** to the funeral director. **Page 4** should be sent to the Chief Medical Examiner's Office along with form PM3. **Page 5** may be retained for **7 days**.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains or removal.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		b. COUNTY Baltimore	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8000 Stevenson Rd.		d. STREET ADDRESS 8000 Stevenson Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Abraham	Middle Krause	Last 4. DATE OF DEATH Sept. 24 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1895
9. AGE (in years last birthday) 61 yrs.		9. AGE (in years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Soft Drinks	11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Fishel		14. MOTHER'S MAIDEN NAME Shefira	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Rose Krause, Pikesville, Md.
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 30 min.			
Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
Due to (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Hour o. m. p. m. none 19	Month, Day, Year 9-25-57	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> none	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Beth Tfiloh
20f. (City or town) Balto.	(County) Md.	(State) 	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>D. D. Caples</i>	DATE SIGNED 9-26-57		
EXAMINER'S NAME (Type) D. D. Caples, M. D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-25-57	22c. NAME OF CEMETERY OR CREMATORIAL Beth Tfiloh	22d. LOCATION (City, town, or county) Balto.
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc., 2100 Eutaw Place	ADDRESS 	24a. REGISTRAR'S SIGNATURE C. Dorothy Y. Lewis	24b. REGISTRAR'S SIGNATURE
		DATE SEP 26 1957	

BUREAU V. S

CD 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9234

CERTIFICATE OF DEATH

0923144

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN b 28 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 824 S. HANOVER STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First KENNY	Middle —	Last LAWRENCE	4. DATE OF DEATH September 16, 1895	Month September	Day 10	Year 1957
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1895	9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore		10b. KIND OF BUSINESS OR INDUSTRY Shipping		11. BIRTHPLACE (State or foreign country) Windsor, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Lawrence				14. MOTHER'S MAIDEN NAME Georgianna MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 231-10-1093		17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OCCLUSION OF RIGHT CORONARY OSTIUM; OLD MYOCARDIAL EDEMA INFARCTION				INTERVAL BETWEEN ONSET AND DEATH 1 MONTH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AORTIC INSUFFICIENCY, MODERATE				UNKNOWN			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) GENERALIZED ARTERIOSCLEROSIS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 13, 1957 to September 10, 1957 , and that death occurred at 8:10A M , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chien Wei Lan</i>				ADDRESS (Street, city or town, state) M.D. VA HOSPITAL, FT. HOWARD, MARYLAND DATE SIGNED 9/10/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-57		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall Hayes, 638 N. Gilmor St., Balto., Md.				24a. REC'D BY REGISTRAR DATE 9/11/57		24b. REGISTRAR'S SIGNATURE <i>Stanley L. Farber</i>	

RECEIVED
BUREAU V. S.

SEP 13 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09232

Reg. Dist. No.

45

9235

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for reference.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. STATE Maryland b. COUNTY Baltimore	
Middle River				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Glen L. Martin		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First James	Middle L.	Last Layton, Sr.	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	Month September Day 23 Year 1957
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	August 7, 1907	9. AGE (In years for birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Industrial Engineer		Glen L. Martin		Baltimore	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
James F. Layton		Bertha Benser		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		049-10-3630		Mrs. Evelyn Layton, 1609 Dolittle Road	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u></u> DUE TO <u></u> (c) <u></u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>M.B. Davis M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <u>9/24/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 26, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Parkwood	
22d. LOCATION (City, town, or county)		(State) Baltimore County, Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Lilly & Zeiler Inc., 403 S. Wolfe St.				DATE 9/25/57	
VS. A15ME(5)		24b. REGISTRAR'S SIGNATURE		<u>Lilly & Zeiler Inc.</u>	
5M 9/55					

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REGELIVE

SEP 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09233

9236

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>		c. LENGTH OF STAY IN lb <i>611 Seminary Ave</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>611 Seminary Ave</i>			d. STREET ADDRESS <i>611 W. Seminary Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Edward</i>	Middle <i>Turner</i>	Last <i>Lee</i>	4. DATE OF DEATH Month <i>9</i>	Day <i>29</i>	Year <i>1957</i>		
5. SEX <i>m</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 27-1904</i>	9. AGE (In years last birthday) yrs. <i>53</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. IF UNDER 24 HRS. Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>chauffeur</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Texas Mds</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Turner Lee</i>			14. MOTHER'S MAIDEN NAME <i>Charlotte Miller</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.					
17. INFORMANT <i>Mary S. Lee</i>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <i>Hypertension</i> DUE TO (c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		Month <i>19</i>	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>St Lukes C</i>	20f. (City or town) <i>Lutherville</i>	(County) <i>Md</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>July 1, 1957</i> to <i>Sept 9, 1957</i> that I last saw the deceased alive on <i>Sept 18, 1957</i> and that death occurred at <i>1:45 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Lutherville, Md</i> DATE SIGNED <i>George T. Gilmore M.D. 9/30/57</i>								
ACTUAL SIGNATURE <i>George T. Gilmore M.D.</i>		PHYSICIAN'S NAME (Type) <i>GEORGE T. GILMORE LUTHERVILLE, MD.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		22b. DATE THEREOF <i>10-2-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St Lukes C</i>		22d. LOCATION (City, town, or county) <i>Henford Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel W. Sullivan Jr. Balti</i>			ADDRESS <i>DATE</i>		24a. REC'D BY REGISTRAR <i>OCT 1 1957</i>		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

TT 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09234
31

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE a. STATE	
<i>Baltimore</i> MARYLAND		<i>Md</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Bryn Mawr</i>		<i>1 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Augsburg Home</i>		d. STREET ADDRESS <i>1123 Bong St.</i>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Year	
<i>Lenna M. Lehman</i>		First <i>Lenna</i>	Middle <i>M.</i>
5. SEX		6. COLOR OR RACE	
<i>F</i>		<i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>May 14 1861</i>	
9. AGE (in years With fractions)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
<i>96 yrs.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Baldo Md</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>John A.</i>		<i>Christine?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown)		16. SOCIAL SECURITY NO.	
<i>No, unknown</i>		<i>—</i>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>103.7</i> DUE TO <i>Acute Cardiac failure</i> INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Arterios Cardiovascular disease</i> (c) <i>Fracture left hip accident</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Sept 11 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) <i>at Augsburg Home</i> 20f. (City or town) <i>Baltimore</i> (County) <i>Md</i> (State) <i>Maryland</i>
21. I certify that I took charge of the remains described above, held of Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> MEDICAL CERTIFICATION ACTUAL SIGNATURE <i>GEO. S. M. KIEFFER M.D.</i> DATE SIGNED <i>Sept 30 57</i> EXAMINER'S NAME (Type) <i>GEO. S. M. KIEFFER M.D.</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-2-57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Matthew Cem.</i>		22d. LOCATION (City, town or county) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Heemann & Son, 6067 Harford Ave. (14)</i>		24a. REC'D. BY REGISTRAR DATE <i>OCT 1 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>Dr. John. Marling</i>	

BUREAU V. S.

1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9238

CERTIFICATE OF DEATH

Reg. Dist. No. 09235

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	c. LENGTH OF STAY IN lb 3 yr	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SHADY NOOK HOME	d. STREET ADDRESS 3249 Shannon Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Julian) Julius	First Thomas	Middle Leyko (Lejko)	4. DATE OF DEATH September 10, 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1873
9. AGE (in years less birthday) 84 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Year Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Valentine Leyko		14. MOTHER'S MAIDEN NAME Caroline M. Kolbusz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James W. Leyko 3249 Shannon Drive.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Advanced arteriosclerotic and hypertensive (c) cardiovascular disease with myocardial degeneration			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Dec. 1950 to 10 Sept. 1957 , that I last saw the deceased alive on 9 Sept. 1957 , and that death occurred at 6:27 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 601 Wmians Way DATE SIGNED 11 Sept 57			
ACTUAL SIGNATURE Emil H Henning Jr		PHYSICIAN'S NAME (Type) Emil H HENNING Jr	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 13, 57	
22c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus		22d. LOCATION (City, town, or county) Dundalk Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		24a. REC'D BY REGISTRAR DATE SET 17 1957	
ADDRESS 2829 Hudson St. 24		24b. REGISTRAR'S SIGNATURE John J. Duda	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

SEP 17 1957

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09236

9239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) RidgeWay Manor		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Thomas Alexander Littlejohns		d. STREET ADDRESS 166 Oaklee Village	
4. DATE OF DEATH Sept. 30, 1957		Month Sept.	Day 30
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
			8. DATE OF BIRTH October 12, 1874
			9. AGE (In years less birthday) 82
			10. IF UNDER 1 YEAR Months 0 Days 0
			11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) New Foundland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Littlejohns		14. MOTHER'S MAIDEN NAME Fannie Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.L & 218-22-0632	17. INFORMANT Address Edna Littlejohns 4304 Fordham Rd.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		Bronchial Pneumonia 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Arteriosclerotic C.V. Disease 10 years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 25, 1957 to Sept 30, 1957 that I last saw the deceased alive on Sept 29, 1957 , and that death occurred at 6:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE John F. Cochran M.D. PHYSICIAN'S NAME (Type) John F. COCHRAN, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 2, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc. 1328 Sulphur Sp.Rd.		24a. REC'D BY REGISTRAR DATE OCT 2 1957	24b. REGISTRAR'S SIGNATURE D. Ambrose

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

AM

FUJIMOTO V. S.

1957

AMERICAN
FEDERATION
OF LABOR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09237

9240

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b 25 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oella Avenue		d. STREET ADDRESS Oella Avenue	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ellen	Middle E.	Last Luers
4. DATE OF DEATH	Month Sept.	Day 6th	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15th. 1873
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Adams Co., Pa.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph A. Hemler		14. MOTHER'S MAIDEN NAME Sarah Buddy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs Louis Dietz, Oella Ave., Oella, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		Coronary Thrombosis	
(c) DUE TO		Cardio-Vascular Renal Disease 7 yrs	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8:30 AM
20f. (City or town) 9, 6		(County) 9, 6 (State) 1957	
21. I certify that I attended the deceased from 9/6 to 9/6 , 1957, that I last saw the deceased alive on 9/6 and that death occurred at 3:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George E. Urban</i>		ADDRESS (Street, city or town, state) 805 Frederick Rd., Catonsville DATE SIGNED 9/7/57	
PHYSICIAN'S NAME (Type) George E. Urban			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 9th 1957	22c. NAME OF CEMETERY OR CREMATORIUM Holy Family Church Cem	22d. LOCATION (City, town, or county) Harrisburg, Balto. Co., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Willis Quinoneau</i>	ADDRESS 4310 Liberty Heights Avenue	24a. REC'D BY REGISTRAR SEP 9 '57	24b. REGISTRAR'S SIGNATURE <i>John J. Walsh</i>

BUREAU N.Y.

SEP 9 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

09238

Item 12, 2411 N. Charles Street, Baltimore

Reg. Dist. No. 38

9241 CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE 5535 Windsor Mill Road COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWSON LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR Armocost Nursing Home		STREET ADDRESS / (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Katherine (First) Josephine (Middle) Lyston (Last)		4. DATE OF DEATH 9 21 1957	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH 97 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Concannon		14. MOTHER'S MAIDEN NAME Mary Donuhue	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT AND ADDRESS Mr. John Lyston - 307 E. 31rst St., Balto. 18
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) Cerebral hemorrhage</p> <p>Antecedent cause(s) (b) Arterio sclerotic cardio vascular disease</p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	White at m.	INJURY OCCURRED Not White Work At work	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 9/20, 1957, to 9/21, 1957, that I last saw the deceased alive on 9/21, 1957 and that death occurred at 2:30 p.m., from the causes and on the date stated above.			
SIGNATURE	(Degree or title)		ADDRESS DATE SIGNED
Philip J. Lyston, MD		11 East Chase Street #2 9/23/57	
23. BURIAL, CREMATION REMOVAL (Specify) DURING	DATE THEREOF 9/25/57	NAME OF CEMETERY OR CREMATORIUM Cathedral Cemetery	LOCATION (City, town, or county) (State) Baltimore Md.
DATE REG'D BY LOCAL REG. 9/25/57	REGISTRAR'S SIGNATURE Mabel Geys	24. FUNERAL DIRECTOR ADDRESS	
J. Freeman Coe & Son			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9169 CERTIFICATE OF DEATH

09239

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>BALTO.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lansdowne</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lansdowne</i>		d. STREET ADDRESS <i>131 2nd Ave.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>131 2nd Ave.</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>Catherine</i>	Middle <i>E.</i>	Last <i>Madary</i>	4. DATE OF DEATH	Month <i>9</i>	Day <i>19</i>	Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>2-19-79</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>JAMES SMITH</i>		14. MOTHER'S MAIDEN NAME <i>Ellen ?</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Family</i>		Address <i>Same</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		B. T R O N C H O - p n e u m o n i a		INTERVAL BETWEEN ONSET AND DEATH <i>24 H</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Organic brain syndrome with severe brain damage, with psychotic reaction.</i>						
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>May</i>	Day <i>7</i>	Year <i>1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Glen Haven Cem.</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Md.</i>	
21. I certify that I attended the deceased from <i>May 7, 1957</i> , to <i>Sept. 19, 1957</i> , that I last saw the deceased alive on <i>Sept. 18, 1957</i> , and that death occurred at <i>1142 M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Florian P Nadolski</i>	ADDRESS (Street, city or town, state) <i>2703 Hammonds Ferry Rd</i>		DATE SIGNED <i>Sept. 23, 1957</i>					
PHYSICIAN'S NAME (Type) <i>Florian P NADOLSKI</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State) <i>Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-23-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Home 130 E. Fort Ave.</i>		ADDRESS <i>McCully Funeral Home 130 E. Fort Ave.</i>		24a. REC'D. BY REGISTRAR <i>SEP 23 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. George Keffey</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EURÉAU V.

SEP 22 195

KLEGELVÉ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09240

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 14 months		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
3. NAME OF DECEASED (Type or print) Rita		4. DATE OF DEATH Lost Malatesta September 15 Year 57	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) unknown	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO no	17. INFORMANT Mrs. Edward Collins	Address 3813 Dorchester Road, Baltimore
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____		2-25-	19 56	September 15, 1957
alive on September 15, 1957,		and that death occurred at 1:50 AM,		that I last saw the deceased
				ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE <u>Stella Wachsler</u>		M.D. SPRING GROVE STATE HOSPITAL		DATE SIGNED 9-16-57
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland		
22a. BURIAL, CREMATION, REMOVAL. (Specify) Burial	22b. DATE THEREOF 9-17-57	22c. NAME OF CEMETERY OR CREMATORIUM NEW CATHEDRAL	22d. LOCATION (City, town, or county) BALTIMORE MD	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schub 2101 Frederick Ave</u>	ADDRESS	24a. REC'D BY REGISTRAR SEP 18 '57	24b. REGISTRAR'S SIGNATURE <u>Albert Deuch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

SEP 18 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0924144

Reg. Dist. No.

9243

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 42 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 5209 Alhambra Avenue		d. STREET ADDRESS Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LOUIS		First P.	Middle MANLY	Last LOUIS	4. DATE OF DEATH SEPTEMBER 2 1957	Month SEPTEMBER	Day 2	Year 1957	IF UNDER 1 YEAR Months 56	IF UNDER 24 HRS. Hours 56	Min. 00
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH February 25, 1901	8. AGE (In years last birthday) 56 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY House painting		10c. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME George R. Manly		14. MOTHER'S MAIDEN NAME Rose Smith									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X CARCINOMA OF THE STOMACH WITH METASTASES TO LIVER, DUE TO AND ABDOMINAL LYMPH NODES AND ASCITIES						INTERVAL BETWEEN ONSET AND DEATH 11 Months					
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH Ft. Howard, Md.		20f. (City or town) VAH Ft. Howard, Md.		(County) VAH Ft. Howard, Md.	(State) VAH Ft. Howard, Md.		
21. I certify that I attended the deceased from July 22 1957 to September 2 1957 and that death occurred at 10:00 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) VAH Ft. Howard, Md.		DATE SIGNED 9/3/57			
ACTUAL SIGNATURE Chien Wet Ian						M.D. VAH Ft. Howard, Md.					
PHYSICIAN'S NAME (Type) CHIEN WET IAN, M.D.						VAH FT. HOWARD, MD		9/3/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-6-57		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight, Inc.		ADDRESS Wm Cook Blight, Inc. 6009 Hanford Rd. Baltimore, Md.				24a. REC'D. BY REGISTRAR 9/4/57		24b. REGISTRAR'S SIGNATURE Levi Cook Blight			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use on the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. G.

DP 5 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9244 CERTIFICATE OF DEATH

09242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 9 Days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 132 North Janney Street		f. DATE OF DEATH September 25 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RAWLINGS HURLOCK MASSEY, SR.	First	Middle	Last	Month	Day	Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1910	9. AGE (In years from birthday) 47	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Brewing Company		11. BIRTHPLACE (State or foreign country) Chestertown, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Josiah Massey		14. MOTHER'S MAIDEN NAME Helen Gooding							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO WW II 216-10-1918		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		HYPERNEPHROMA WITH METASTASIS TO LUNGS				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
180 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from September 16 1957 to September 25 1957 and that death occurred at 2:05 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			DATE SIGNED 9/25/57
ACTUAL SIGNATURE <i>Irving Freeman</i>		M.D. VETERANS ADMINISTRATION HOSPITAL							
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D. Chief Medical		FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/28/57	22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery	22d. LOCATION (City, town, or county) Chestertown, Maryland				(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles Edward Schimunek Funeral Home, 2601 E. Madison St., Baltimore 5, Maryland		ADDRESS		24a. REC'D BY REGISTRAR SEP 30 1957	24b. REGISTRAR'S SIGNATURE <i>Edward J. Farley</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 14 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUDEAU V.

SEP 22 1957

KELLOGG
CEREAL CO.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09243

Reg. Dist. No.

9243

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PHA3. Page 5 may be retained for your records.

TO FURNITURE: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Balto		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Trenton - Rural		Trenton - Rural	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
5 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
SALLIE - E - MAYS			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Female	W	WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
6. COLOR OR RACE	7. MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <input type="checkbox"/>
W	DIVORCED <input type="checkbox"/>	July 13-1865	92 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Hulk	Maryland	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address	
William H Tracey	Annie E Morfoot		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
No			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris DUE TO 420.1 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic coronary artery disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
None			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE	DATE SIGNED		
2.2. E. ap. lea	9-30-57		
EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	Oct 2-1957	Mr. Daniel	Baltimore Co Md
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Edele & Tipton Hampstead Md		DATE 9-30-57	Mary B. Sline

BUREAU V. S.

DET C 1922

DEGELVIL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3. It should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09244

9246

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Armagh Village (Balto.12)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Armagh Village (Balto.12)		d. STREET ADDRESS 209 S. Tyrone Road					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 S. Tyrone Roed				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CLARENCE		First	Middle WILLIAM	Last McCOLLOUGH	4. DATE OF DEATH Sept. 21, 1957	Month Sept.	Day 21	Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 17, 1904	9. AGE (in years last birthday) 53 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Broker		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Food Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Grant McCollough		14. MOTHER'S MAIDEN NAME Genevia Almomy									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-28-8139		17. INFORMANT Mrs. Eva McCollough, 209 S. Tyrone Rd., Balto.12		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute coronary occlusion (2nd) 5 min.									
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b) Arteriosclerotic cardiovascular disease 5 yrs.									
		DUE TO (c) First coronary occlusion - June 1954.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>June</u> , 1954, to <u>Sept. 21</u> , 1957, that I last saw the deceased alive on <u>Sept. 18</u> , 1957, and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)									
ACTUAL SIGNATURE <i>Lloyd E. Saylor</i>		DATE SIGNED <u>9/23/57</u>									
PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M. D.		M. D. 3902 Greenmount Avenue									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 24, 1957		22c. NAME OF CEMETERY OR CREMATORIUM New Freedom Cemetery		22d. LOCATION (City, town, or county) New Freedom, Pa.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Burns - 10/24/57</i>		ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR Sept. 24, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray					
VS A15 (4) 1SM 9/55											

EUREAU V.

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REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9247 CERTIFICATE OF DEATH

09245

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page **1** may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page **2** should be filed with the funeral director.

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER. 54 20	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Hawthorn Rd		d. STREET ADDRESS 11 Hawthorn Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGARET E McGrath		First M	Middle A
4. DATE OF DEATH 9 21 1957	Month 9	Day 21	Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W	8. DATE OF BIRTH 1-17-1869
9. AGE (In years month/birthday) 88 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Md	12. CITIZEN OF WHAT COUNTRY? —
13. FATHER'S NAME LAWRENCE McGrath		14. MOTHER'S MAIDEN NAME CATHERINE Biggin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Marie Hughes.		Address JAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arterio-sclerotic cardio-vascular disease			
INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 20 1957 to Sept 21 1957 that I last saw the deceased alive on Sept 20 1957 , and that death occurred at 5:10A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE JOSEPH MICELI		ADDRESS (Street, city or town, state) 108 S Taylor Ave Essex 2, Md	
PHYSICIAN'S NAME (Type) JOSEPH MICELI		DATE SIGNED 9/23/57	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-57	
22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery		22d. LOCATION (City, town or county) Balto Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. Bugginakis 1407 Eastern Ave		24a. REC'D BY REGISTRAR D 25 100	
ADDRESS J. Bugginakis 1407 Eastern Ave		24b. REGISTRAR'S SIGNATURE John K. Murphy	

BUREAU V. S.

SEP 25 1957

KIEGELEV E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09246

Reg. Dist. No.

9248

CERTIFICATE OF DEATH

44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VAH FORT HOWARD, MD.		c. LENGTH OF STAY IN lb 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1114 N. Kenwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Frank J. McKenna		First	Middle	Last	4. DATE OF DEATH September 14 1957	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1920		9. AGE (in years lost birthday) 36 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank McKenna		14. MOTHER'S MAIDEN NAME Eleanor Kelly						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) YES		16. SOCIAL SECURITY NO. 215-14-6646		17. INFORMANT Clin Rec. Vet Adm Hosp., Ft. Howard, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH unknown		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CIRRHOSIS OF THE LIVER FAR ADVANCED						
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		BLEEDING ESOPHAGEAL VARICIES SECONDARY TO #1		unknown		
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that <input checked="" type="checkbox"/> attended the deceased from September 4 1957, to Sept. 14, 1957, and that death occurred at 5:12 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Harold R. Johnson</i>						ADDRESS (Street, city or town, state)		DATE SIGNED
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M. D.		VAH, Fort Howard, Md.				9/15/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/57		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National		22d. LOCATION (City, town, or county) 5501 Frederick Ave, Balto., Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Flight Funeral Home, 6009 Harford Rd.		ADDRESS Balto., Md.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE SEP 17 1957 Dawson L. Farley		

BUREAU V. S

SEP 10 1977

REGELIVE

6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9249 CERTIFICATE OF DEATH

19247

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Baltimore MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
House in The Pines 16 Fusing Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Anna		M.	Mehrling
4. DATE OF DEATH		Month	Day
		Sept.	28
			19 57
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
F.		W.	8. DATE OF BIRTH
			July 8, 1878
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
79 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Saleslady		Kuhfuss Bakery	Md.
12. CITIZEN OF WHAT COUNTRY?		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Henry Mehrling		Mary Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
			Mrs William Foxworth, 618 N.Hilton St.
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Acute myocardial insufficiency		2 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic cardio-vascular disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 6, 19 54, to Sept. 28, 19 57, that I last saw the deceased alive on September 28, 19 57, and that death occurred at 5:00P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>George A. Knipp</i>		M.D. 4116 Edmondson Avenue Baltimore 29, Maryland 9/30/57	
PHYSICIAN'S NAME (Type) George A. Knipp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 1/57	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE OCT 2 '57	24b. REGISTRAR'S SIGNATURE <i>Reba Knipp</i>

BUREAU V. S.

OCT 2 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9250

CERTIFICATE OF DEATH

09248

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X C Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		d. STREET ADDRESS 2533 Westport Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) WILLIAM	First H.	Middle MILLER, Sr.	Last Sept. 27, 1957
4. DATE OF DEATH Month Year	Month Sept.	Day 27	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar 11, 1872
9. AGE (In years last birthday) 85	10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	11. IF UNDER 24 HRS. yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mould Maker		10b. KIND OF BUSINESS OR INDUSTRY Carr-Lowrey Glass Co.	11. BIRTHPLACE (State or foreign country) Millville, N.J.
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Frederick Miller		14. MOTHER'S MAIDEN NAME Elizabeth Dempsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-01-3840A	17. INFORMANT Mr. William H. Miller, Jr.—516 Shipley Road
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute pulmonary edema</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>atherosclerotic cardiovascular disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months 1 yr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>large st. inguinal hernia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) 20h. (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE JOHN A. NESBITT, JR.	M.D. 1118 St. Paul St. Baltimore 2, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/30/57	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.	22d. LOCATION (City, town, or county) Balto., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hickner & Sons - Balt. 17th	ADDRESS 9/30/57	24a. REC'D BY REGISTRAR 9/30/57	24b. REGISTRAR'S SIGNATURE John J. Hickner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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100

REGGIEVILLE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (1924)

9161

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7452 Laurence Road		d. STREET ADDRESS 7452 Laurence Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ANTHONY C. MILLI	Middle	Last
4. DATE OF DEATH	Month Sept.	Day 10	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1904
9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanley Milli		14. MOTHER'S MAIDEN NAME Sophia Rudolph	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W W 11	
17. INFORMANT Mrs. Alice Milli 7452 Laurence Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 min.	
COPD		COPD	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-19-57 to 9-10-57, that I last saw the deceased alive on 6-19-57, and that death occurred at 3:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 9-12-57	
ACTUAL SIGNATURE Jack C Collins	M.D.	22. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Sept. 14, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Belair Memo. Gardens	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24a. REG'D BY REGISTRAR DATE SEP 17 1957	
		24b. REGISTRAR'S SIGNATURE Mr. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REFUGEE

SEP 1957

PIREAU V. 8

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09250

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville

c. LENGTH OF STAY IN lb

23yr5mth24dys

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Spring Grove State Hospital

3. NAME OF
DECEASED
(Type or print)
First Donald Johnson Morgan

Last

4. DATE
OF
DEATH
Sept. 16

Month
Year
19 57

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Oct. 17, 1892

9. AGE (In years
last birthday)

64 yrs

10. UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

travelling salesman

10b. KIND OF BUSINESS OR INDUSTRY

photography

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles H. Morgan

14. MOTHER'S MAIDEN NAME

Laura Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

unknown

17. INFORMANT

Records: SPRING GROVE STATE HOSPITAL

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

33/X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c) b. CEREBRAL VASCULAR ACCIDENT

b. CEREBRAL & GENERALIZED ARTERIOSCLEROSIS

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a. m.
p. m. 19

20d. INJURY OCCURRED
White Not white
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

George M. Kieffer, M. D.

DATE SIGNED

EXAMINER'S
NAME (Type)

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

9-16-57

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

9/18/57

22c. NAME OF CEMETERY OR CREMATORIUM

Oak Lawn Cemetery

22d. LOCATION (City, town, or county)

(State)

Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Wm Cook-Bright Inc. 6009 Harford Rd

DATE SEP 17 '57

Quesenbach

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2 57

BUREAU V. S

SEP 18 1957

REGELVÉO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09251

9252 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 Ridge Road				d. STREET ADDRESS 23 Ridge Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Charles A. H. Mueller		First	Middle	Last	4. DATE OF DEATH Sept. 2, 1957.
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1875		9. AGE (in years birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Mueller		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Curtis F. Davis, 610 N. Chapelgate Lane.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) SECONDARY ANEMIA - CACHEXIA		INTERVAL BETWEEN ONSET AND DEATH			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE John H. Shaw		ADDRESS (Street, city or town, state) 5801 Edmondson Ave., Baltimore, Md. DATE SIGNED Sept. 5, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 5/57		22c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave.		ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR SEP 6 '57	
				24b. REGISTRAR'S SIGNATURE D. L. Schuch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

BUREAU V. S.

7 3 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09252

9253 CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverside Maryland 7 yrs.</i>		c. LENGTH OF STAY IN 1b <i>7 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Caves Road.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i>	
f. STREET ADDRESS <i>Caves Road</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Charles</i>	Middle <i>Alexander</i>	Last <i>Munn Jr</i>
4. DATE OF DEATH	Month <i>Sept</i>	Day <i>5</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 25, 1913</i>
9. AGE (In years last birthday) <i>43 yrs.</i>	10. IF UNDER 1 YEAR Months <i>4</i>	11. IF UNDER 24 HRS. Days <i>5</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>Charles Alexander Munn</i>	14. MOTHER'S MAIDEN NAME <i>Mary A. Paul</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>	16. SOCIAL SECURITY NO. <i>261-40-5150</i>	17. INFORMANT <i>Mrs C.A. Munn Jr Caves Rd, Maryland</i>	Address <i>Caves Rd, Maryland</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Amotrophic lateral sclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), causing the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>808 Reisterstown Rd</i>	20f. (City or town) (County) (State) <i>Pikesville</i>
21. I certify that I attended the deceased from <i>July</i> , 19 <i>57</i> , to <i>5 Sep</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>30 Aug</i> , 19 <i>57</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Pikesville</i> DATE SIGNED <i>5 sep 57</i>			
ACTUAL SIGNATURE <i>Paul H Royse</i>	M.D.		
PHYSICIAN'S NAME (Type) <i>Paul H Royse</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/6/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Druid Ridge</i>	22d. LOCATION (City, town, or county) (State) <i># Pikesville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>K.W. Meeks</i>	ADDRESS <i>Box 805 N. Calvert St</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 6 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Mary Glince</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

SEP 6 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9254

CERTIFICATE OF DEATH

09253

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rasburg		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 412 Walcott Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY		First NIES	Middle Henry
4. DATE OF DEATH Sept. 17, 1957		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 23, 1897	
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Nies		14. MOTHER'S MAIDEN NAME Kate Heiger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Rachel Nies 412 Walcott Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1 month	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Cerebral hemorrhage	
DUE TO (c)		Hypertension cardio vascular disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. 51. Month Aug. Day 22 Year 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 22, 1957 to Sept. 17, 1957 , that I last saw the deceased alive on Sept. 16, 1957 , and that death occurred at 6:10 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Charles M. Kerr MD Baltimore 6 Md	
ACTUAL SIGNATURE <i>Charles M. Kerr</i>		DATE SIGNED Sept. 17, 1957	
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Sept. 20, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn	
22d. LOCATION (City, town, or county) Colgate, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home 4210 Belair Road.		24a. REGD. BY REGISTRAR DATE SEP 02 1957	
		24b. REGISTRAR'S SIGNATURE A. L. Reissner	

BUREAU V. S.

SEP 20 1977

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9255

CERTIFICATE OF DEATH

09254

Reg. Dist. No.

33

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Gilead Road		d. STREET ADDRESS Mt. Gilead Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Jennie	Middle Rozella	Last Osborn		
4. DATE OF DEATH	Month Sept. 24, 1957	Day 19	Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1899		
9. AGE (In years lost birthday) 58	10. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME George F. Wagner	14. MOTHER'S MAIDEN NAME Rebecca Ann Leppo				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Wm. Edgar Osborn, Reisterstown, Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation			INTERVAL BETWEEN ONSET AND DEATH 21 mos.		
449X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Chronic Hypertensive C-V Disease			8 yrs.		
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) No	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none				
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work none	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) none	(County)	(State)
21. I certify that I attended the deceased from 12-1-36 , 19____, to 9-24-57 , 19____, that I last saw the deceased alive on 9-23-57 , 19____, and that death occurred at 8:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 9-27-57					
ACTUAL SIGNATURE D. D. Caples	M.D.				
PHYSICIAN'S NAME (Type)	D. D. Caples, M. D. Reisterstown, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 27/57	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Gilead	22d. LOCATION (City, town, or county) Reisterstown, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md.	ADDRESS	24a. REC'D BY REGISTRAR Sept. 27-57	24b. REGISTRAR'S SIGNATURE Mary B. Eline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD A. S.

1957

EDGAR V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09255

9256

CERTIFICATE OF DEATH

Reg. Dist. No.

10
1. PLACE OF DEATH
a. COUNTY

Baltimore MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN lb

50 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland.

b. COUNTY

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

734 Charing Cross

e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

d. STREET ADDRESS

734 Charing Cross

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

Sept. 25, 1957

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

M.

W.

WIDOWED DIVORCED

July 26, 1892

65

yrs

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Clerk In Charge U.S. Postal Trans.

Pocomoke City

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)16. SOCIAL SECURITY NO.
(If yes, give war or dates of service)

17. INFORMANT

Address

Mrs Anna Paradee, 734 Charing Cross

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

ARTERIOSCLEROTIC HEART DISEASE

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

CARCINOMA - STOMACH

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.20d. INJURY OCCURRED
White Not white
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)21. I certify that I attended the deceased from 8-12, 1957, to 9-25, 1957, that I last saw the deceased
alive on 9-25-57, 1957, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Hugh W. Brown M.D. 1103 ST. PAUL ST.

9-26-57

PHYSICIAN'S
NAME (Type)

REMOVAL (Specify)

Burial

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Sep. 28/57

22b. DATE THEREOF

Loudon Park Cem.

22c. NAME OF CEMETERY OR CREMATORIUM

Balto. Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Witzke Funeral Directors, 4101 Edmondson Ave.

ADDRESS

24a. REC'D BY REGISTRAR

DATE SEP 28 1957

24b. REGISTRAR'S SIGNATURE

Burke

BUREAU V. 8
KREGEL V. 8

SEP 30 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09256

9257 CERTIFICATE OF DEATH

Reg. Dist. No. 43

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>		c. LENGTH OF STAY IN 1b <i>x 2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>307 Willow Avenue</i>		e. STREET ADDRESS <i>307 Willow Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Walter Franklin Preston</i>		4. DATE OF DEATH Month <i>September 14</i> Year <i>1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 10, 1885</i>
9. AGE (In years last birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Government</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Edgewood Arsenal</i>	
10c. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Preston</i>		14. MOTHER'S MAIDEN NAME <i>Sarah</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-16-9936</i>	
17. INFORMANT <i>Mrs. Sophia C. Preston, 307 Willow Ave.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i>		<i>Acute cardio vascular collapse</i> <i>3 hr.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>		<i>Coronary thrombosis with infarction 4 hrs.</i>	
DUE TO cause (a), stating the underlying cause last. <i>(c)</i>		<i>Coronary heart disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic emphysema and bronchial asthma</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>	
20c. TIME OF INJURY Hour a. m. <i>— 19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7-8</i> , 19 <i>54</i> , to <i>left</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Sept 4, 1957</i> , and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>6801 Belair Road #6</i>	
ACTUAL SIGNATURE <i>Charles M. Kerr</i>	PHYSICIAN'S NAME (Type) <i>Dr. Charles M. Kerr.</i>	DATE SIGNED <i>Sept 16, 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/17/1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Zion Cemetery</i>	22d. LOCATION (City, town or county) (State) <i>Harford Co. Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 19 1957</i>
			24b. REGISTRAR'S SIGNATURE <i>Marie L. Keyne</i>

YREAU V.

1957

THE GENEVIEVE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File Pages 1, 2 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09257 40

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Kingsville		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X-2 Kingsville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Belair Rd & New Cut Rd Belair Rd & New Cut Rd		e. 12. RES. IN FARM ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First BERTHA	Middle MAY	4. DATE OF DEATH Sept. 28 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1891
9. AGE (In years to day)	66 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? Address	U.S.A.		
13. FATHER'S NAME Victor Bond	14. MOTHER'S MAIDEN NAME May Temple		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, if unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Husband Above Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Cedam's Stokes Syndrome, Sudden Myocardial Enlargement, Hypertension.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH None	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) None		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED White of work Not white of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank T. Kasik Jr.</i>	DATE SIGNED Sept 28, 1957		
EXAMINER'S NAME (Type) FRANK T. KASIK JR.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 2, 1957	22c. NAME OF CEMETERY OR CREMATORIUM St. John's	22d. LOCATION (City, town, or county) Kingsville, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Sarah Funeral Home	ADDRESS 7401 Belair Rd.	RECD BY REGISTRAR OCT 1 DATE	24b. REGISTRAR'S SIGNATURE 1957 Dr. Walter Johnson

BUREAU Y. 4
REFUGEE

CT 1 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9259

CERTIFICATE OF DEATH

1925897
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt Wilson Md</i>	c. LENGTH OF STAY IN lb <i>1b</i>	b. COUNTY <i>Montgomery</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Springs</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MT Wilson State Hospital</i>	d. STREET ADDRESS <i>1219 Remington Dr</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Alberta Bolton</i>	First <i>Reed</i>	Middle <i>Bolton</i>	Last <i>Alberta</i>
4. DATE OF DEATH <i>Sept 21 1957</i>	Month <i>Sept</i>	Day <i>21</i>	Year <i>1957</i>
5. SEX <i>Femal</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-12-1909</i>
9. AGE (in years last birthday) yr. <i>48</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Punch Press Oper.</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Gen. Motors</i>	11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S</i>
13. FATHER'S NAME <i>Clarence Bolton</i>	14. MOTHER'S MAIDEN NAME <i>Louise Nevious</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>153-18-9909</i>	17. INFORMANT <i>Hospital Records Mt Wilson State Hosp.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Tuberculosis; Far adu.</i> DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i> (b) <i>Atelectasis and Pneumonia Lpt</i> DUE TO (c) <i>Pneumonectomy - Rt.</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Segmental Resection Lpt Lung.</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fracture of skull, brain hemorrhage, death.</i>		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Colonial Memo Park</i>	20f. (City or town) <i>Trenton N.J.</i>
(County) <i>Montgomery Co.</i>		(State) <i>N.J.</i>	
21. I certify that I attended the deceased from <i>1-16-57</i> , 19 <i>57</i> , to <i>9-21-57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>9-21-57</i> , 19 <i>57</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>William Newcomer M.D. Mt Wilson Md</i>			DATE SIGNED <i>9-21-57</i>
ACTUAL SIGNATURE <i>William Newcomer</i>	PHYSICIAN'S NAME (Type) <i>William Newcomer</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>9/25/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Colonial Memo Park</i>	22d. LOCATION (City, town, or county) <i>Trenton N.J.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Hartman & Sons Trenton, N.J.</i>		ADDRESS <i>Per Frank W. Newell, Attala St. Md.</i>	24a. REC'D. BY REGISTRAR DATE <i>EP 25 1957</i>
			24b. REGISTRAR'S SIGNATURE <i>Dorothy Knoll</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

SEP 25 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9260 CERTIFICATE OF DEATH

09259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Belair Road, Glen Arm P.O.		d. STREET ADDRESS Belair Road, Glen Arm P.O.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First John	Middle G.	Last Reichert	4. DATE OF DEATH	Month Sept.	Day 20	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/14/1876	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Philipp Reichert		14. MOTHER'S MAIDEN NAME Katherine Elizabeth Schroeder						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. Catherine Reichert Belair Rd. Glen Arm PO		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480X DUE TO acute Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 24 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO La Grippe 10 days (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —						
20c. TIME OF INJURY Hour o. g. p. m.	Month 1	Day 19	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from 9-17, 1957 , to 9-20, 1957 , that I last saw the deceased alive on 9-19, 1957 , and that death occurred at 1P M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Clifford F. Hudson</i>	ADDRESS (Street, city or town, state) FORK, MD.						DATE SIGNED SEP 27 1957	
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/23/57	22c. NAME OF CEMETERY OR CREMATORIUM St. Michaels Cemetery		22d. LOCATION (City, town, or county) Perry Hall		(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Funeral Home		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR SEP 27 1957	24b. REGISTRAR'S SIGNATURE J. Walter, Secretary			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELVÆR

BUREAU V. S.

SEP 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09260

Reg. Dist. No.

9261

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Caton Ridge Manor Nursing Home, Harlee Lane				d. STREET ADDRESS Armisted Gardens 1106 Quantril Way	
3. NAME OF DECEASED (Type or print) Maude M. Rhinebolt		First	Middle	Last	4. DATE OF DEATH Month Day Year Sept. 13, 1957
5. SEX FFemale	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mch. 10. 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Penna	
13. FATHER'S NAME William Zimmerman		14. MOTHER'S MARRIED NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Charles E. Rhinebolt Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac failure DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease Hypertensive DUE TO					
(c) Diabetes Mellitus					
(d) Fracture left femur Accident					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture corrected by operation at St. Agnes Hospital					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item) Fracture and Fell down steps (stone) at home causing injury lacertions			
20c. TIME OF INJURY Hour o. m. p. m. May 9, 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Baltimore	(County) (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		DATE SIGNED Sept. 13, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Sept. 15, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Leichty Cemetery	22d. LOCATION (City, town, or county) Somerset Co. Pa. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.		ADDRESS 1217 St. Paul St.	24a. REC'D BY REGISTRAR SEP 17 '57		24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>

DIRTY MEDICAL EXAMINEE This certificate should be filled within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains, prior to burial, cremation, or removal.

BUREAU V. S.
RECEIVED
SEP 17

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9262

CERTIFICATE OF DEATH

09262

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD.		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLIOTT CITY		d. STREET ADDRESS Rt. 144 2802 Frederick Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First SAMUEL	Middle WILLIAM	Last RIDGELEY	4. DATE OF DEATH Month 9	Day 11	Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11-21-1885	9. AGE (in years from birth) 73 yrs.	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) SYKESVILLE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL G. RIDGELEY		14. MOTHER'S MAIDEN NAME MARY ANN HUGHES		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 214-05-2965		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pleural effusion DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) General arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. 19 <input type="checkbox"/> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-19 , 1957, to 9-21 , 1957, that I last saw the deceased alive on 9-21-57 , and that death occurred at 392 1/2 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Barrett, Md. DATE SIGNED							
ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland							
PHYSICIAN'S NAME (Type) William Newcomer, M. D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-57		22c. NAME OF CEMETERY OR CREMATORIAL Highland View		22d. LOCATION (City, town, or county) (State) Barrett, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 9 P Ridgeley Hwy, Ellicott City, Md.		ADDRESS Highland View		24a. REC'D BY REGISTRAR DATE SEP 23 1957		24b. REGISTRAR'S SIGNATURE Dorothy Powell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK

APR 23 1957

REGULATED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9263 CERTIFICATE OF DEATH

09262

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		e. STREET ADDRESS 708 Winan's Way		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZABETH		First A.	Middle ROBINSON	Last	4. DATE OF DEATH Sept.	Month 1,	Day 19 57
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 24, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS. Days —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Frederick Schlimme		14. MOTHER'S MAIDEN NAME —					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. Harry L. Robinson - 708 Winan's Way		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Canceromatosis DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of RF Breast DUE TO (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 1 , 1956 to Sept. 1 , 1957, that I last saw the deceased alive on Sept. 1 , 1957, and that death occurred at 5:30 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 9/3/57 DATE SIGNED							
ACTUAL SIGNATURE A.P. Von Schulz M.D. PHYSICIAN'S NAME (Type) A.P. Von Schulz M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/57		22c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Vicker & Sons - Balt. 17th				ADDRESS 18 SEP 6 57 Q. W. Beach			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			

RECEIVED
BUREAU V. S.

SEP 9 1977

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9264

CERTIFICATE OF DEATH

Reg. Dist. No.

0926331

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edgewood Rd.		d. STREET ADDRESS Edgewood Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle M.	Last RODDY
4. DATE OF DEATH	Month 7	Day 11	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1878
9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Simon Roddy		14. MOTHER'S MAIDEN NAME Susan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. C. Gardner Disney - Edgewood Rd. Address Randallstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Nat white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/10, 1957, to 9/11, 1957, that I last saw the deceased alive on 9/10, 1957, and that death occurred at 6:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Edwin L. Pierpont M.D. 8204 LIBERTY RD, BALTO, MD 9/11/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/57	
22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cem.		22d. LOCATION (City, town, or county) Woodlawn, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Pickard & Sons. Baltimore		24a. REC'D BY REGISTRAR SEP 16 1957	
		24b. REGISTRAR'S SIGNATURE John Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

RECEIVED
FBI BUREAU WASH D.C.
SEP 16 1954

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9265

CERTIFICATE OF DEATH

09264
Sag. Dist. NB.

30

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Phoenix			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Phoenix Rd.				d. STREET ADDRESS Phoenix Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Price Royston		First	Middle	Lost	4. DATE OF DEATH 9-16-57	Month	Day Year 19
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-8-1873	9. AGE (In years last birthday) yrs 84	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marion Royston				14. MOTHER'S MAIDEN NAME Susanna Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT E. F. Royston, Phoenix, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X				Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO		arteriosclerosis			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE, 1957, to Sept 16 th , 1957, that I last saw the deceased alive on Sept. 13 th , 1957, and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED m. x. quinn M.D. 1927 York Rd, Timonium, Md. 9/16/57							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) MICHAEL KEVIN QUINN M.D. 1927 YORK RD, TIMONIUM, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-18-57		22c. NAME OF CEMETERY OR CREMATORIAL St. James Episcopal		22d. LOCATION (City, town, or county) Monkton, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks		ADDRESS 622 York Rd. Towson # 4, Ma.		24a. REC'D BY REGISTRAR SEP 18 1957		24b. REGISTRAR'S SIGNATURE Elly Grunberg	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records of the funeral home.

VS A15 (4)
15M 9/55

RECEIVED
BUREAU V. A.

SEP 18 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1819265

9266

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swings Mills (R)</u>		c. LENGTH OF STAY IN 1b <u>3 year</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer Park Road</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>Deer Park Road</u>	
3. NAME OF DECEASED (Type or print) <u>Martin A. Ruppert</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>19</u> Year <u>1957</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <u>Thor. 27, 1895</u>	8. DATE OF BIRTH 9. AGE (In years last birthday) 61 m.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing Inspector Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing Inspector Inspector</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>William Ruppert</u>	
14. MOTHER'S MAIDEN NAME <u>Magdalena Grossman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <u>yes</u>	
16. SOCIAL SECURITY NO. <u>Edith Lippincott, Randallstown</u>		17. INFORMANT Address <u>Edith Lippincott, Randallstown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 440.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Myocarditis</u> DUE TO (c) <u>Arteriosclerosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>50 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>57</u> , to <u>Sept. 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 19</u> , 19 <u>57</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Martin</u>		ADDRESS (Street, city or town, state) <u>Randallstown</u> M.D. DATE SIGNED <u>Sept 21/57</u>	
PHYSICIAN'S NAME (Type) <u>John E. Martin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>9/23/57</u>		22c. NAME OF CEMETERY OR CREMATORIAL CHAPEL <u>Wards Chapel</u>	
22d. LOCATION (City, town or County) <u>Liberty Road</u> (State) <u>Md</u>		24a. REC'D BY REGISTRAR <u>John E. Martin</u> DATE <u>9/24/57</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		24b. REGISTRAR'S SIGNATURE	
ADDRESS			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PUREA V. S.

GCD 64 1007

PEGELV E D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9267

CERTIFICATE OF DEATH

Reg. Dist. No.

09266

45

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		c. LENGTH OF STAY IN 1b RURAL and give nearest town MIDDLE RIVER X0	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2805 OAKLAND AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THELMA C. RUPPRECHT		First	Middle
4. DATE OF DEATH SEPT. 13 1957		Last	Month
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2/2/1914		9. AGE (In years last birthday) 43 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY PENN	
11. BIRTHPLACE (State or foreign country) PENN		12. CITIZEN OF WHAT COUNTRY? SAME AS ABOVE	
13. FATHER'S NAME ISAAC CONRAD		14. MOTHER'S MAIDEN NAME ORA COULTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-34-4768	
17. INFORMANT WM. RUPPRECHT		Address INTERVAL BETWEEN ONSET AND DEATH 2 WKS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Canceroma larynx & trachea		DUE TO Circumna stomach	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. 151X		DUE TO (b) Circumna stomach	
(c)		DUE TO (c)	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) BALTO. CO. MD. (State)	
21. I certify that I attended the deceased from SEPT 13 1957 to SEPT 13 1957 that I last saw the deceased alive on SEPT 13 1957 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Lewis Semenoff M.D. 2108 (BCMS 15) DATE SIGNED 9/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL SEPT. 17-1957		22b. DATE THEREOF ZION LUTHERAN	
22c. NAME OF CEMETERY OR CREMATORIUM ZION LUTHERAN		22d. LOCATION (City, town, or county) BALTO. CO. MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly		24a. ADDRESS Eased 21 and SEP 18 1957 Edith Turley	
		24b. REC'D BY REGISTRAR DATE	
		24c. REGISTRAR'S SIGNATURE	

RECEIVED
BUREAU V. A.

SEP 18 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 092672

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE M.D.		b. COUNTY BALTO						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ENGLISH CONSUL		c. LENGTH OF STAY IN 1b 6 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ENGLISH CONSUL		d. STREET ADDRESS 2805 LOUISIANA AVE						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2805 LOUISIANA AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) GEORGE HENRY SCHAEFER		First	Middle	Last	4. DATE OF DEATH SEPT 14 1957	Month	Day	Year				
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC-2-1875	9. AGE (In years lost birthday) 81 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCKER		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R		11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? ALBERT						
13. FATHER'S NAME HEINRICH G. SCHAEFER		14. MOTHER'S MAIDEN NAME LENA ALBRIGHT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) ✓		16. SOCIAL SECURITY NO 705 05 8450						
17. INFORMANT EMMA E. MC KELDIN		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA - HEAD OF PROSTATE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 9300 YRS						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) CARDIO-VASCULAR DISEASE - ARTERIOSCLEROSIS		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BALTIMORE	20f. (City or town) BALTIMORE	(County) MARYLAND	(State) MARYLAND
21. I certify that I attended the deceased from 19 OCT 1957 to 14 SEPT 1957 , that I last saw the deceased alive on 6 SEPT 1957 , and that death occurred at 10 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Edward F. Milan		ADDRESS (Street, city or town, state) 682 WASHINGTON BLVD BALTIMORE MD 21205		DATE SIGNED 9/15/57								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 17, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park		22d. LOCATION (City, town, or county) BALTIMORE		(State) MARYLAND				
23. FUNERAL DIRECTOR'S SIGNATURE John F. Seigel, 5311 Edmondson St.		ADDRESS John F. Seigel, 5311 Edmondson St.		24a. REC'D BY REGISTRAR DATE 16 1957		24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Tupper						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 17 1962

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9268

09268

Items 11 & 12, Film 9220, 9/26/57, 18

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balt. o. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Villa Julie				d. STREET ADDRESS Valley Rd.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Sister Mary Rosina (Schneiderhan)		First	Middle	Last	4. DATE OF DEATH	Month Sept. 21	Day Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPT. 16, 1895		9. AGE (In years lost birthday) 61 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Religious		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN SCHNEIDERHAN				14. MOTHER'S MAIDEN NAME ANNA KRAFT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Villa Julie Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1957x</i> DUE TO <i>Cancer lungs</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Cancer breast.</i> (c) <i>5-6 yrs</i>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Jan 1957, to Aug 21, 1957, that I last saw the deceased alive on Aug 20, 1957, and that death occurred at 2 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Harold H. Burns</i> M.D. ADDRESS (Street, city or town, state) <i>115 E. Eager St. Baltimore Md.</i> DATE SIGNED <i>9-23-57</i>								
PHYSICIAN'S NAME (Type) <i>Harold H. Burns</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-57		22c. NAME OF CEMETERY OR CREMATORIUM Trinity Convent		22d. LOCATION (City, town, or county) Ilchester		
(State) Md.								
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Farley Funeral Home Catonsville Md.,				24a. REC'D BY REGISTRAR DATE SEP 24 '57		24b. REGISTRAR'S SIGNATURE <i>Auerbach</i>		

BUREAU V. L.

SEP 04 1957

LEO V. L.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09269

9269

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3015 Woodside Ave.</i>		d. STREET ADDRESS <i>3015 Woodside Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Louis</i>	Middle <i>J.</i>	Last <i>Schruter</i>
4. DATE OF DEATH	Month <i>Sept. 21,</i>	Day <i>1957</i>	Year
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 1, 1886</i>
9. AGE (In years lost birthday) yrs. <i>71</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Bedding</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Schruter</i>	14. MOTHER'S MAIDEN NAME <i>Teresa</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>213031328</i>	17. INFORMANT <i>Mrs. Myrtle Cimino</i>	Address <i>3015 Woodside Ave. #14</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163X</i> DUE TO <i>Carcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Carcinoma of lung			
INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks 4 months</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>—</i> 19 p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/21</i> , 1952, to <i>9/26</i> , 1952, that I last saw the deceased alive on <i>was d.o.b.</i> , 19, and that death occurred at <i>430 p.m.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George H. Beck M.D.</i>	ADDRESS (Street, city or town, state) <i>Charles St 34th St Baltimore, Md.</i>		
PHYSICIAN'S NAME (Type) <i>GEORGE H. BECK</i>	DATE SIGNED <i>9/26/52</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>9/25/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc.</i>	ADDRESS <i>5305 Harford Rd.</i>	24a. REC'D BY REGISTRAR <i>SEP 25 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Arch. M. Bacon</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REFUGEE

SEP 25 1957

BUREAU X-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09270

Reg. Dist. No.

42

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		Edith Elizabeth Schulz MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Baltimore MD		c. LENGTH OF STAY IN lb		a. STATE Md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL or largest town)		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Oaklee, Arbutus		Oaklee, Arbutus 29 Balto. Co		X-	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
919 Leeds Ave Oaklee		919 Leeds Ave Oaklee		19	
3. NAME OF DECEASED (Type or print)		First Edith Elizabeth Middle Scholz Last		4. DATE OF DEATH Month Sep. 28 Day 1957 Year 19	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Aug. 5 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md	
House wife				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Kiesling		14. MOTHER'S MAIDEN NAME Mary Shadec		Address 919 Leed an	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. Not		17. INFORMANT Myrtle Jones	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.0 DUE TO Acute Cardiac Failure					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cardiovascular disease					
(c) DUE TO Accident Fracture right femur or hip					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Jan. 11 57 fell on the floor causing a fracture of her leg.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE (b) PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> Cause of Death. Jan. 11 57 fell on the floor causing a fracture of her leg.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell on the floor causing fracture of Femur Right.			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 9:30 P.M Jan. 11, 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
				20f. (City or town) Oaklee Arbutus Balto. Co. Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE Geo. M. Kieffer		DATE SIGNED			
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct. 1-57 Meadow Park		22b. DATE THEREOF Oct. 1-57		22c. NAME OF CEMETERY OR CREMATORIAL BALTO - MD.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR OCT 2 1957 24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Kieffer	

DRUG V.S

100 gm

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09271

9162

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Balto.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colgate</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colgate</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>17820 Eastern Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>EMMA</i>	Middle <i>Schweiger</i>	Last <i></i>	4. DATE OF DEATH <i>9 - 27</i>	Month <i>1957</i>	Day	Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-10-1878</i>	9. AGE (In years last birthday) <i>79</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Hours <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT-HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Fred Appel</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>EDWARD Schweiger (same)</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs.</i>		
4221 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO								
(c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month <i>July</i>	Day <i>24</i>	Year <i>1957</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>July</i> , 19 <i>49</i> to <i>Sept.</i> , 19 <i>57</i> that I last saw the deceased alive on <i>Sept. 24</i> , 19 <i>57</i> , and that death occurred at <i>2:00 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>3023 Eastern Ave.</i>		DATE SIGNED <i>9/30/57</i>
ACTUAL SIGNATURE <i>Clarence W. Leboux</i>		PHYSICIAN'S NAME (Type) <i>Clarence W. Leboux, M.D.</i>		Baltimore, 24, Maryland				

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>9-30-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>OAK-FAWN</i>	22d. LOCATION (City, town, or county) <i>Balto</i>	(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Connelly</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i>DATE 10-2-57</i>	24b. REGISTRAR'S SIGNATURE <i>Wm. M. Kelly, Jr.</i>	E.T.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 2 1955

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10409
38

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

9270

1. PLACE OF DEATH a. COUNTY	Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE Maryland b. COUNTY Baltimore
c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) #2 Bridge, Loch Raven Baltimore City Morgue			d. STREET ADDRESS Paca & Fayette Sts.

3. NAME OF DECEASED (Type or print)	First ALDON	Middle BAIR	Last Sharpe	4. DATE OF DEATH	Month September	Day 24	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/13/27	9. AGE (In years last birthday) 30 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Painting	11. BIRTHPLACE (State or foreign country) Minersville Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Allan Sharpe Sr.	14. MOTHER'S MAIDEN NAME Lena Bertram		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 209-14-9615	17. INFORMANT Mrs. Lena Sharpe 850 Water St. Pottsville	Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 729.8 DUE TO Conditions, if any, which gave rise to immediate cause (a) (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Working as painter dropped Brush Seven feet	

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) See #1	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE Charles F O'Donnell	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 9/29/57
EXAMINER'S NAME (Type) Charles F O'Donnell	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 30, 57	22c. NAME OF CEMETERY OR CREMATORIAL Govans Presbyterian	22d. LOCATION (City, town, or county) Baltimore, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Deacon	ADDRESS 4600 Liberty Heights	24a. REC'D BY REGISTRAR DATE 9/30/57	24b. REGISTRAR'S SIGNATURE Dr. A. M. Bacon
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

100

REGIMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09272															
CERTIFICATE OF DEATH															
Reg. Dist. No. 38															
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson				c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Notch Cliff near Towson											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road				d. STREET ADDRESS Glenarm Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Sister Mary Josephine Siegrist	Middle	Last	4. DATE OF DEATH	Month Sept.	Day 11	Year 1957							
5. SEX		6. COLOR OR RACE Female	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1875	9. AGE (In years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 82	11. IF UNDER 24 HRS. Days hrs.	12. IF UNDER 24 HRS. Hours 48 hrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS				11. BIRTHPLACE (State or foreign country) Sellersville, Pa.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Henry				14. MOTHER'S MAIDEN NAME Johanna Klein											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Sister M. Peter Fourier				Address Notch Cliff, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which goes rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 48 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 m. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug. 27, 1955, to Sept. 10, 1957, that I last saw the deceased alive on Sept. 10, 1957, and that death occurred at 10:35M, from the causes and on the date stated above.												ADDRESS (Street, city or town, state) 1501 York Rd. Towson 4, Md. DATE SIGNED 9.11.57			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>				M.D.											
PHYSICIAN'S NAME (Type) Charles F. O'Donnell															
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 9-13-57		22c. NAME OF CEMETERY OR CREMATORIUM VILLA MARIA CEM. NOTCH CLIFF NR TOWSON, MD.				22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles F. O'Donnell</i>				ADDRESS 901 S. CONKLING ST., BALTO. 24, MD.				24a. REC'D BY REGISTRAR SEP 16 1957				24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>			

RECEIVED
BUREAU A.S.A.

SEP 17 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9272

CERTIFICATE OF DEATH

09273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13yr7mth22dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland		d. STREET ADDRESS 5301 Taylor Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Aslang	Middle Hiortdahl	Last Silvey	4. DATE OF DEATH 9	Month 9	Day 8	Year 19 57
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1878	9. AGE (In years last birthday) 78	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? Norway	
13. FATHER'S NAME Richard Hiortdahl		14. MOTHER'S MAIDEN NAME Josephine Prince					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Carcinoma of stomach		INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Leiile brain disease - generalized seizure's death						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 12 , 19 57 , to 9-8 , 19 57 , that I last saw the deceased alive on 9-8-57 , 19 57 , and that death occurred at 10 P.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>J. Vasconcellos</i>		PHYSICIAN'S NAME (Type) J. VASCONCELOS		SPRING GROVE STATE HOSPITAL		9-8-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-19-57		22b. DATE THEREOF 9-19-57		22c. NAME OF CEMETERY OR CREMATORIUM b of med. Med. Schoole		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REG'D BY REGISTRAR SEP 20 1957		24b. REGISTRAR'S SIGNATURE Allie Green	

HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 14 hours after death; page 1 by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 & 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09274 45**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tranit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLGATE		b. COUNTY BALTO.	
c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLGATE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7531 CYPRESS Ave.		d. STREET ADDRESS 7531 CYPRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES L. SIMMONS		First J.	Middle L.
		Last SIMMONS	
4. DATE OF DEATH SEPT 3 1957		Month SEPT	Day 3
		Year 1957	
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
			8. DATE OF BIRTH 3-29-1893
9. AGE (in years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
		12. IF UNDER 1 YEAR Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED.	11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES L. SIMMONS SR.		14. MOTHER'S MAIDEN NAME LAMBERT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No, no, unknown		16. SOCIAL SECURITY NO. 212 185448	17. INFORMANT CARROLL SIMMONS (SAME)
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) A-S-C-V Disease		DUE TO (c) Not Known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Not Known	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Not Known
		20f. (City or town) BALTO.	(County) MD.
		(State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis M.D.		DATE SIGNED 9/4/57	
EXAMINER'S NAME (Type) M. B. DAVIS M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-6-57	22c. NAME OF CEMETERY OR CREMATORIAL Oak LAWN Cem
		22d. LOCATION (City, town, or county) BALTO.	
		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly, Esq. - Md.		24a. RECEIVED BY REGISTRAR REP 6	24b. REGISTRAR'S SIGNATURE 1957 Edith Turley
		DATE 1957	

MANUFACTURERS

© - 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3
the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9274

CERTIFICATE OF DEATH

Reg. Dist. No.

092753

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills, 17 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto. City</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood St. Training school</i>		d. STREET ADDRESS <i>4820 Wright St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>DONALD</i>	Middle <i>RALPH</i>	Last <i>SIMONDS</i>
4. DATE OF DEATH <i>SEPT. 16</i>	Month <i>Sept.</i>	Day <i>16</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-29-35</i>
9. AGE (In years last birthday) <i>27 246 yrs.</i>		10. IF UNDER 1 YEAR Months <i>27</i>	
11. IF UNDER 24 HRS. Days <i>24</i>		12. IF UNDER 24 HRS. Hours <i>6</i>	
13. FATHER'S NAME <i>EARL E. SIMONDS</i>		14. MOTHER'S MAIDEN NAME <i>Pearl Weaver</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>ROBERT RY. ROSEWOOD TRAINING SCHOOL</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BILATERAL LOBAR PNEUMONIA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>ASPIRATION DURING EPILEPTIC SEIZURE</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>GRAND MALT & PETIT MALT EPILEPSY, MENTAL DEFICIENCY</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Hour o. m. p. m.	Month <i>Sept.</i>	Day <i>16</i>	Year <i>1957</i>
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9-5</i> , 19 <i>52</i> , to <i>9-15</i> , 19 <i>52</i> , that I last saw the deceased alive on <i>SEPT. 16</i> , 19 <i>57</i> , and that death occurred at <i>8:55 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Rosewood St. TRAINING SCHOOL</i>			
ACTUAL SIGNATURE <i>HARRY G. BUTLER</i>	M.D.	DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>HARRY G. BUTLER</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>OWINGS MILLS, MARYLAND</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/20/57</i>	22c. LOCATION (City, town, or county) <i>Maryland</i>	(State) <i>N.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Brooks Bradley Jr.</i>	ADDRESS <i>Dundalk, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 17</i>	24b. REGISTRAR'S SIGNATURE <i>Mary Blues</i>

BUREAU V. 8
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SEP 10 1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 0927639

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>	c. LENGTH OF STAY IN TB <i>4 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X? Sparks</i>	d. STREET ADDRESS <i>1 York Rd</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>York Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lula Rivers Slaughter</i>		4. DATE OF DEATH <i>September 2 1957</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>31 January 1878</i>
9. AGE (In years last birthday) <i>85 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>	
11. BIRTHPLACE (State or foreign country) <i>Elisca, Alabama</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Ridley Rivers</i>		14. MOTHER'S MAIDEN NAME <i>Estelle Agee</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Son Frank Slaughter</i>		Address <i>Sparks Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i>31 October 1957</i>
20f. (City or town) <i>Owings</i>		(County) (State) <i>1957</i>	
21. I certify that I attended the deceased from <i>31 August 1957</i> to <i>2 Sept 1957</i> , 1957, that I last saw the deceased alive on <i>31 August 1957</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		ADDRESS (Street, city or town, state) <i>Cockeysville Rd</i>	
PHYSICIAN'S NAME (Type) <i>Walter T. KEEES</i>		DATE/SIGNED <i>2 Sept 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-5-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Monroeville</i>
22d. LOCATION (City, town, or county) <i>Monroeville, Alabama</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J Scott Brooks</i>		24a. REC'D BY REGISTRAR <i>SEP 4 1957</i>	24b. REGISTRAR'S SIGNATURE <i>J. Scott Brooks</i>
ADDRESS <i>622 York Rd., Towson</i>		DATE	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EUREAU V

SEP 4 1957

PAGE ONE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09277

38

9276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto</i>	c. LENGTH OF STAY IN 1b <i>30 yr</i>	b. COUNTY <i>Balto</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2810 Emerald Rd.</i>		d. STREET ADDRESS <i>2810 Emerald Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>James</i>	First <i>Payne</i>	Middle <i>Smith</i>	Last <i>Sept 19</i>
4. DATE OF DEATH <i>1957</i>	Month <i>Sept</i>	Day <i>19</i>	Year <i>1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 24 1867</i>
9. AGE (In years last birthday) <i>89 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Balto Salesbook</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia P.A.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Frank Smith</i>	14. MOTHER'S MAIDEN NAME <i>Julia Payne</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>212-12-9834</i>	17. INFORMANT <i>Doughy</i>	Address <i>ETHel Zerehaut</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Adams Stokes syndrome	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Arteriosclerotic heart disease.	
(b)		2+ yrs	
DUE TO Age -			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>Dec</i>	Day <i>15</i>	Year <i>1957</i>
20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>9005 Harford Rd</i>	20f. (City or town) <i>Balto</i>	(County) <i>Md</i>
(State) <i>Md</i>			
21. I certify that I attended the deceased from <i>Aug 5</i> , 1957, to <i>Dec 15</i> , 1957, that I last saw the deceased alive on <i>Aug 5</i> , 1957, and that death occurred at <i>9005 Harford Rd</i> , 1957, M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>9005 Harford Rd</i>			
DATE SIGNED <i>9/19/57</i>			
ACTUAL SIGNATURE <i>Frank T. Kasik Jr.</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>FRANK T. KASIK JR.</i>		BALTO 14 / Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>9-26-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Western Mem</i>	22d. LOCATION (City, town, or county) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford</i>	
24a. REC'D BY REGISTRAR <i>SEP 23 1957</i>		24b. REGISTRAR'S SIGNATURE <i>J. W. Gacons</i>	

BUREAU V. S

SEP 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9277

CERTIFICATE OF DEATH

Reg. No. 09278

44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN lb 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 1952 W. Mulberry Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle (NONE)	Last SMITH	4. DATE OF DEATH	Month September	Day 13	Year 1957
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> ANNULLED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/93	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ROXBORO, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Smith		14. MOTHER'S MAIDEN NAME Martha Spruell		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO WW I 218-01-7226		17. INFORMANT Clin. Rec. Folder, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] CEREBRAL THROMBOSIS							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) GENERALIZED ARTERIOSCLEROSIS; DIABETES MELLITUS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 30, 1957 , to Sept. 13, 1957 , and that death occurred at 2:00 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED							
ACTUAL SIGNATURE Edward A. Foster M.D.							
PHYSICIAN'S NAME (Type) EDWARD A. FOSTER, M. D. VAH, Fort Howard, Md. 9/14/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/18/57		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balt. Md.							
ADDRESS				24a. REC'D BY REGISTRAR 9/17/57		24b. REGISTRAR'S SIGNATURE Edward L. Farley	

RECEIVED
FBI BUREAU W. A.

SEP 10 1957

1

TO HOSPITAL OR ATTEND **PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 221 10-18-57 ams

9278

CERTIFICATE OF DEATH

09279

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 49 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 125 Cheapside St		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First JOHN	Middle SOUDER
4. DATE OF DEATH September 26 1957	Month September	Day 26	Year 1957
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1896
9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groom		10b. KIND OF BUSINESS OR INDUSTRY Race Track	
11. BIRTHPLACE (State or foreign country) Pitman, New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John H. Souder		14. MOTHER'S MAIDEN NAME Hattie Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 321-07-6687	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
DUE TO 18-X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		PRIMARY TO BE DETERMINED/ Primary site Kidneys	
DUE TO 18-X			
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA		20f. (City or town) Ft. Howard	
		(County) Baltimore	
		(State) Md.	
21. I certify that I attended the deceased from August 8, 1957 to September 26, 1957 , and that death occurred at 10:15 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Veterans Administration Hospital			
DATE SIGNED 9/26/57			
ACTUAL SIGNATURE Chien Wei Lan			
M.D.			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/57	
22c. NAME OF CEMETERY OR CREMATORIUM St. Peter's Cemetery		22d. LOCATION (City, town, or county) 1300 Moreland Ave. Balt. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Bright, Jr.		ADDRESS 6009 Harford Rd Balt. Md.	
		24. REG'D BY REGISTRAR DATE SEP 27 1957	
		24b. REGISTRAR'S SIGNATURE Dawson J. Thorne	

BUREAU V. A.

SEP 04 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9163

CERTIFICATE OF DEATH

0928041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
Dundalk BALTO. MARYLAND		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3119 Dunglow Road		d. STREET ADDRESS 3119 Dunglow Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ANTONIA	Middle SPORNY	4. DATE OF DEATH Sept. 10, 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1880
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Gowski		14. MOTHER'S MAIDEN NAME Telepilia ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Agnes Frado 3119 Dunglow Road.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 6 M.O.S.	
(b) DUE TO Arteriosclerosis.		20 years	
(c) Hypertension		20 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 4</u> , 1957, to <u>Sept 10</u> , 1957, that I last saw the deceased alive on <u>Sept 4</u> , 1957, and the death occurred at <u>1A</u> , M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>David H. Andrew</u> PHYSICIAN'S NAME (Type) <u>David H. Andrew, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 13, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart Cemetery		22d. LOCATION (City, town or county) Dundalk, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home 2112 Dundalk Ave.,		24a. REC'D BY REGISTRAR DATE SEP 13 1957	
		24b. REGISTRAR'S SIGNATURE <u>J. M. Kelley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

SEP 13 1957

REGEVIEW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9279

CERTIFICATE OF DEATH

09281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>BALTO. CO.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>		b. COUNTY <i>Baltimore</i>			
c. LENGTH OF STAY IN lb <i>9 yr.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9 Delrey Ave</i>		d. STREET ADDRESS <i>9 Delrey Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>ARCELINA R. STEC</i>	First <i>A</i>	Middle <i>R.</i>	Last <i>STEC</i>		
4. DATE OF DEATH <i>9/17</i>	Month <i>9</i>	Day <i>17</i>	Year <i>1957</i>		
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/11/90</i>		
9. AGE (In years, last birthday) <i>67 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>	11. BIRTHPLACE (State or foreign country) <i>Poland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>P —</i>	14. MOTHER'S MAIDEN NAME <i>R —</i>	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>026 072 523</i>	17. INFORMANT <i>Erene Stauffer</i>	18. INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		CARCINOMA UTERUS.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>O</i>			
20c. TIME OF INJURY Hour a. m. p. m. <i>0 19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>0</i>	20f. (City or town) <i>0</i>	(County) <i>0</i>	(State) <i>0</i>
21. I certify that I attended the deceased from <u>3/16</u> , 19 <u>56</u> , to <u>SEPT. 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>SEPT. 7</u> , 19 <u>56</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>J. Lloyd Johnson</i>	ADDRESS (Street, city or town, state) <i>6348 FREDERICK ROAD CATONSVILLE MARYLAND.</i>		DATE SIGNED		
PHYSICIAN'S NAME (Type) <i>S. LLOYD JOHNSON M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/11/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Towson Park</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John McMillan Jr.</i>	ADDRESS <i>28</i>	24a. REC'D BY REGISTRAR DATE SEP 11 '57	24b. REGISTRAR'S SIGNATURE <i>Archae</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 11 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

*item 18: G221 10/9283

CERTIFICATE OF DEATH

Reg. Dist. No.

092883

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	c. LENGTH OF STAY IN lb 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	d. STREET ADDRESS 2723 FAIRMOUNT AVE				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosedale State Training School	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) LENFORD TYRONE STERRETT	First	Middle	Last				
4. DATE OF DEATH SEPT 21 1957	Month	Day	Year				
S. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 18, 1949	9. AGE (In years lost birthday) yrs. 7 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME John Robert Sterrett		14. MOTHER'S MAIDEN NAME Blanche Wilsonia Barrow		Address 2723 Fairmount Ave Baltimore 29, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr + Mrs J. P. Sterrett		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 355X DUE TO pneumonia - 2 days * INTERVAL BETWEEN ONSET AND DEATH 2-da	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. —		(b) Schilder's Disease) Positive diagnosis, DUE TO of symptoms - 18 mos. - Dr. Harris 10-4-57		(c) 10½ mos; duration of symptoms - 18 mos. - Dr. Harris 10-4-57			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 17, 1957 , to Sept. 21, 1957 , that I last saw the deceased alive on Sept. 21, 1957 , and that death occurred at 7:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Rosedale St Tr. School. DATE SIGNED ACTUAL SIGNATURE Olive Reid Harris							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 11 1957		22c. NAME OF CEMETERY OR Crematory Balto. National Cemetery		22d. LOCATION (City, town, or county) Balto. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Williams		ADDRESS 3229 Columbia St		24a. REC'D BY REGISTRAR Mary Glens		24b. REGISTRAR'S SIGNATURE	
VS A15 (4) 15M 9/55							

KIEGEI V FE
BUREAU V. E

SEP 25 1957



Rosewood State Training School

George C. Shambaugh, M.D.
Superintendent

Owings Mills, Maryland
Tel: Hunter 6-5200

Albert W. Clark
Administrative Asst.

VISITING DAYS: TUESDAY, THURSDAY,
SUNDAYS AND HOLIDAYS
1:00 P.M. TO 4:00 P.M.

October 2, 1957

OCT 4 1957

State of Maryland
Department of Health
201 N. Charles Street
Baltimore 18, Maryland

Re: Linford Tyrone Starrett

Att: Mrs. Leidy

Gentlemen:

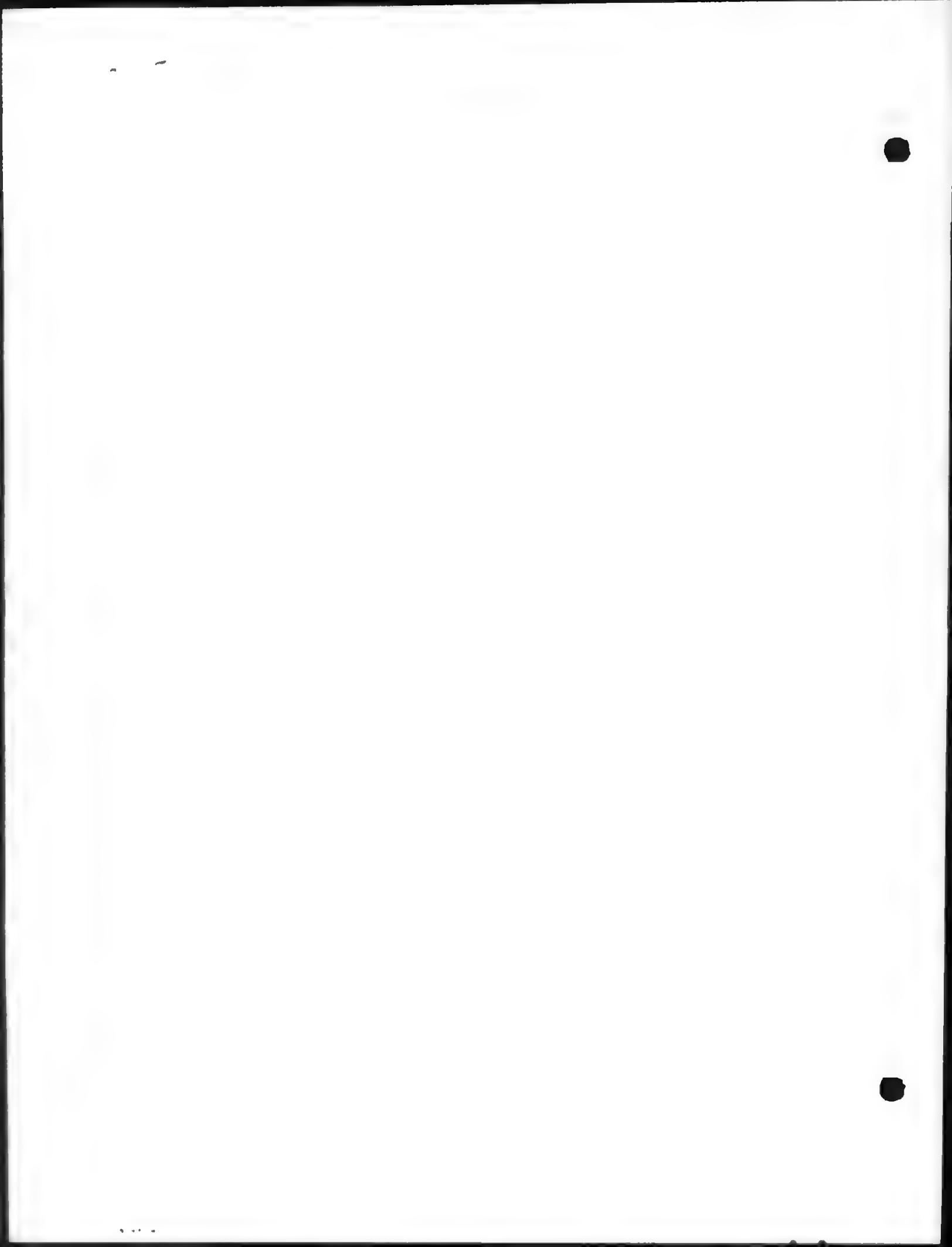
In reply to your letter of September 30, 1957 requesting definite information for Death Certificate of duration of illness on Linford Tyrone Starrett, the immediate cause of death was listed as pneumonia - duration 2 days, and Schilder's Disease - positive diagnosis 10 $\frac{1}{2}$ months, duration of symptoms 18 months. Therefore, in my opinion the certificate should read - pneumonia 2 days, Schilder's disease 18 months.

I regret any inconvenience this may have caused you and hope that the above information is sufficient.

Very truly yours,

Olive Reid Harris, M.D.
Olive Reid Harris, M.D.

orb/ps



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09284

The

THIS IS A PERMANENT RECORD.

PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUEBLACK IN—DO NOT USE A BALL POINT PEN.
 Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly.
 THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1. NAME OF DECEASED (Type or Print)		9292 CERTIFICATE OF DEATH		Reg. Dist. No. 40
SOPHIE M. STOKES		STOKES		2. DATE OF DEATH 29 Sept 1957
3. PLACE OF DEATH A. Baltimore City, Maryland Raphael Road		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
B. FULL NAME OF HOSPITAL OR INSTITUTION If not in hospital or institution, give street address or location		A. STATE Georgia		B. COUNTY
C. CITY OR TOWN Atlanta				
c. LENGTH OF STAY IN BALTIMORE		Yrs. 2	Mos. 1	Days 20
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH June 12, 1882
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 75
13. FATHER'S NAME Charles Mc Alister		14. MOTHER'S MAIDEN NAME Virginia Earle		12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. C. A. Stokes-80 Osner Dr.-Atlanta, Ga.
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 hrs.
ANTECEDENT CAUSES		(A) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO		Hypertensive Heart Disease 16 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO		Angina Pectoris 10 yrs.
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? NOT WHILE AT WORK <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 1956, that (I) (we) last saw the deceased alive on and that death occurred at 6 A.m., from the causes and on the date stated above.				March 1956
23A. SIGNATURE ATTENDING PHYS. <i>Edward Muller</i> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23B. ADDRESS 24 Kead St		23C. DATE SIGNED 29 Sept 1957
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 9/30/57	24C. NAME OF CEMETERY OR CREMATORIUM Christ Church Cemetery	24D. LOCATION (City, town, or county) (State) Greenville, South Carolina
DATE RECEIVED BY LOCAL REGISTRAR 10/1/57		REGISTRAR'S SIGNATURE <i>Dr Walter Hammitt</i>	25. FUNERAL DIRECTOR <i>Wm. J. Jackson & Sons</i>	ADDRESS

RECEIVED
UNIVERSITY OF TORONTO LIBRARIES

UNIVERSITY OF TORONTO LIBRARIES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9281

CERTIFICATE OF DEATH

1928340

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore , Glen Arm		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Glen Arm		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm, Md.		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm, Maryland		d. STREET ADDRESS Glen Arm, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Glen Arm, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Catherine		First	Middle	Last	4. DATE OF DEATH Stewart	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/90	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Thomas Renner		14. MOTHER'S MAIDEN NAME Mary Gleason						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Francis Phelps, Glen Arm, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Primary Carcinoma of Liver</i>		DUE TO				INTERVAL BETWEEN ONSET AND DEATH 9 months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO						
DUE TO		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore (State) Md.
21. I certify that I attended the deceased from <u>June 9, 1957</u> to <u>August 20, 1957</u> , that I last saw the deceased alive on <u>August 20, 1957</u> , and that death occurred at <u>J M</u> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 11 E. Chase St.		
ACTUAL SIGNATURE Milton Sheary		PHYSICIAN'S NAME (Type) Milton Sheary		M.D.		DATE SIGNED 7/7/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/57		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore		22d. LOCATION (City, town, or county) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook - Towson Inc.		ADDRESS York Road		24a. REC'D BY REGISTRAR 9/10/57		24b. REGISTRAR'S SIGNATURE Dr Walter Kennedy		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELIVE

SEP 11 1977

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09285

Reg. Dist. No.

9283

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 15yr8mth28dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Adams Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lester	Middle 	Last Storm	4. DATE OF DEATH September 7 19 57	Month September	Day 7	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1910	9. AGE (In years from birth) 47 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) storekeeper		10b. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Storm		14. MOTHER'S MAIDEN NAME Emma Long					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic pericardial tamponade DUE TO 162X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac metastasis DUE TO (c) Bronchogenic carcinoma, right INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 5 1957 to Sept. 7 1957 , that I last saw the deceased alive on Sept. 7 1957 , and that death occurred at 10:15pm , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE	Stella Wachsler		M.D.	SPRING GROVE STATE HOSPITAL 9-9-57			
PHYSICIAN'S NAME (Type)	Stella Wachsler, M. D.		Catonsville 28, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 10, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Grace Methodist Cemetery	22d. LOCATION (City, town, or county) Falls Rd., Cockeysville, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE John Barnes, Miss Dawson 4	ADDRESS DATE SEP 11 '57	24a. REC'D BY REGISTRAR John Barnes, Miss Dawson 4	24b. REGISTRAR'S SIGNATURE John Barnes, Miss Dawson 4				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REF ID: A6512

WMAU V. 5

SEP 11 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 P-10286 9-10-57 at

09286 45

9284

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>)		b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ESSEX MD.</i>		c. LENGTH OF STAY IN 1b <i>30 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ESSEX MD. 4</i>		d. STREET ADDRESS <i>RT. #13 Box 837 Pottowm. Rd.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hospital Box 837 Pottowm. Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>J. Thomas</i>	Middle <i>J.</i>	Last <i>STOEVER</i>	4. DATE OF DEATH <i>Sept. 3 1957</i>	Month <i>Sept.</i>	Day <i>3</i>	Year <i>1957</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-15-1883</i>		9. AGE (in years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel Louis Pt. J.V.</i>		11. BIRTHPLACE (State or foreign country) <i>Louis Pt. J.V.</i>					
13. FATHER'S NAME <i>Jacob</i>		14. MOTHER'S MAIDEN NAME <i>Stoever</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>216-10-4029</i>		17. INFORMANT <i>Mrs. Eva B Stoever</i>		Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>420.0</i>		DUE TO <i>CORONARY OCCLUSION</i>				INTERVAL BETWEEN ONSET AND DEATH <i>15 MIN.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>ARTERIO-SCLEROTIC HEART DISEASE</i>		DUE TO <i>420.0</i>		(c) <i>2 yrs</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>LOBAR PNEUMONIA</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>108 S. TAYLOR AVE</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>JAN. 15, 1952</i> , to <i>SEPT. 3, 1957</i> , that I last saw the deceased alive on <i>AUG. 31, 1957</i> , and that death occurred at <i>4:45 AM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>108 S. TAYLOR AVE</i>		DATE SIGNED <i>9/3/57</i>			
ACTUAL SIGNATURE <i>Joseph Miceli</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>JOSEPH MICELI M.D.</i>		ESSEX 21 MD.							
22a. BURIAL, CREMATION, BURIAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-6-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cem.		22d. LOCATION (City, town, or county) <i>Baltimore Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John C. Miller Inc.</i>		ADDRESS <i>-2431 E. Oliver St.</i>		24a. REC'D BY REGISTRAR <i>SEP 5 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Edith Turley</i>			
VS A15 (4) ISM 9/55									

RECEIVED
BUREAU V. S.

SEP 25 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9285 CERTIFICATE OF DEATH

09287

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #1 EDGEWATER TERRACE	
d. STREET ADDRESS #1 EDGEWATER TERRACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLES.	Middle F.	Last STRECKFUS
4. DATE OF DEATH Aug -9, 1957	5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH 3/11/1901	9. AGE (in years from birth) 56 yrs.	10. IF UNDER 1 YEAR Months 9 Days 14	11. IF UNDER 24 HRS Hours 14 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK, STANDARD OIL (RET.)		10b. KIND OF BUSINESS OR INDUSTRY MD.	
10c. BIRTHPLACE (State or foreign country) ALSA		12. CITIZEN OF WHAT COUNTRY? ALSA	
13. FATHER'S NAME HENRY STRECKFUS		14. MOTHER'S MAIDEN NAME BARBARA FEHR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-01-4361	
17. INFORMANT MILDRED STRECKFUS		18. Address 1 EDGEWATER TERR.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			
DUE TO (c)			
Coronary thrombosis (occlusion)			
INTERVAL BETWEEN ONSET AND DEATH 1/2 hour			
Coronary insufficiency			
11 years			
Arterio sclerosis			
11 yrs +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
Diabetes mellitus, mild			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-28-57 to 8-12-57 , that I last saw the deceased alive on 8-12-57 , and that death occurred at 9:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene C. Baumann		ADDRESS (Street, city or town, state) 413 Eastern Av., Essex, Md. - 9-14-57	
PHYSICIAN'S NAME (Type) Eugene C. Baumann		DATE SIGNED 9-14-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/17/57	
22c. NAME OF CEMETERY LOUDON PARK		22d. LOCATION (City, town, or county) BALTO.	
23. FUNERAL DIRECTOR'S SIGNATURE Clarence F. Hoffmann		23. ADDRESS 3218 Jackson St.	
		(24)	
24a. REC'D. BY REGISTRAR ED 18 1957		24b. REGISTRAR'S SIGNATURE Edith Hurley	
VS A15 (4) 15M 9/55			

BUREAU V. A.

SEP 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09288

9286 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Towson	c. LENGTH OF STAY IN 1b	a. STATE	Maryland					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Towson Nursing Home		b. COUNTY	Baltimore					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
3. NAME OF DECEASED (Type or print)		First Mrs.	Middle Katherine	d. STREET ADDRESS	8323 Pleasant Plains Road					
4. DATE OF DEATH		Month September	Day 8	Year 1957						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 13 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Housewife				Baltimore, Maryland		USA				
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Stoffel								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Amyotrophic lateral sclerosis</i> DUE TO <i>356.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <i>9/1/57</i> , 1957, to <i>9/18</i> , 1957, that I last saw the deceased alive on <i>9/8</i> , 1957, and that death occurred at <i>11:45 P.M.</i> from the causes and on the date stated above.								ADDRESS (Street, city or town, state)	DATE SIGNED <i>9/9/57</i>	
ACTUAL SIGNATURE <i>Edward Gordon Grau</i>		M.D.						22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		
PHYSICIAN'S NAME (Type) <i>Edward Gordon Grau</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/11/1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Ludon Park Cem.</i>		22d. LOCATION (City, town, or county) <i>(State)</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road.</i>		24a. REC'D. BY REGISTRAR <i>S.P. 2-100</i>		24b. REGISTRAR'S SIGNATURE <i>Edward Gordon Grau</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

REGELEY L.L.C.
SEP 12 1977

REGELEY L.L.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09289

9287 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
f. STREET ADDRESS 1026 Barre Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Stanley	Middle Sukstya	4. DATE OF DEATH Month 9 / Day 15 / Year 19 57
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 1, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) iron worker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lithuania
13. FATHER'S NAME Paul Sukstya		14. MOTHER'S MAIDEN NAME Anna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 9, 1957 to Sep. 15, 1957 , that I last saw the deceased alive on September 15, 1957 , and that death occurred at 8:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Bruno Radauskas</i>	PHYSICIAN'S NAME (Type) BRUNO RADAUASKAS M.D. SPRING GROVE STATE HOSPITAL		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-18-7	22c. NAME OF CEMETERY OR CREMATORIAL Most Holy Redeemer
22d. LOCATION (City, town, or county) BELLOIR RD MD.		24a. REC'D BY REGISTRAR DATE SEP 18 1957	
23. FUNERAL DIRECTOR'S SIGNATURE C W Kochanekas		24b. REGISTRAR'S SIGNATURE John E. Smith	ADDRESS 703 Mc Henry St #50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 18 1957

KODAK SAFETY FILM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09290

9288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b X 3 Lutherville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broadway Road		e. STREET ADDRESS Broadway Road	
3. NAME OF DECEASED (Type or print) ANNE		First ANNE	Middle HOWELL
		Last TAYLOR	4. DATE OF DEATH Sept. 24, 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) New Jersey
13. FATHER'S NAME B. Frank Howell		14. MOTHER'S MAIDEN NAME Ruth G. Gandy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none	17. INFORMANT Mr. J. Carey Taylor - Broadway Rd., Lutherville
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<i>Carcinoma of Breast</i> INTERVAL BETWEEN ONSET AND DEATH 18 mo.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 4, 1957 to Sept. 24, 1957 that I last saw the deceased alive on Sept. 24, 1957 , and that death occurred at 11 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 2217 South Rd. Sept 25	
ACTUAL RESIDENCE PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 9/27/57	22c. NAME OF CEMETERY OR CREMATORIAL Green Mount Crem.	22d. LOCATION (City, town, or county) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. McElroy & Sons - Balt. 17261</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 27 '57	24b. REGISTRAR'S SIGNATURE <i>Albert Smith</i>

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNAU V. S

SEP 5 1967

U.S. GOVERNMENT
PRINTING OFFICE: 1967

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9289 CERTIFICATE OF DEATH**

09291 30
Reg. Date No ~~108~~

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata, Maryland		d. STREET ADDRESS La Plata, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Walter	Middle D.	Last Taylor	4. DATE OF DEATH September 16 1957	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1881	9. AGE (in years less birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plasterer		10b. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William W. Taylor				14. MOTHER'S MAIDEN NAME Rebecca E. Slack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 186-12-9845A		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		DUE TO Terminal pneumonia		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerotic cardiovascular disease		DUE TO (b)					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SPRING GROVE STATE HOSPITAL		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 11, 1957 to Sept. 16, 1957 , that I last saw the deceased alive on Sept. 16, 1957 , and that death occurred at 4:00a M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED 9-16-57							
ACTUAL SIGNATURE Stella Wachsler		PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-57		22c. NAME OF CEMETERY OR CREMATORIUM Jonesboro		22d. LOCATION (City, town, or county) Jonesboro (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Chesburt Inc. Soplets-Md.		ADDRESS Chesburt Inc. Soplets-Md.		24a. REGD BY REGISTRAR DATE 9/19/57		24b. REGISTRAR'S SIGNATURE Julia H. Henry	

BUREAU V. S

SEP 20 1957

REGELIVEO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09292

9172

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5506 Osage Avenue		d. STREET ADDRESS 218 N. Hilton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Female		First Anna	Middle Florence	Last Tewey	4. DATE OF DEATH September 4, 1957	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1903	9. AGE (In years lost birthday) 54 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
13. FATHER'S NAME Bernard F. Gallery		14. MOTHER'S MAIDEN NAME Anna Ross		12. CITIZEN OF WHAT COUNTRY? U.S.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Leo M. Tewey, Sr. 218 N. Hilton Street		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 170X		INTERVAL BETWEEN ONSET AND DEATH Carcinoma of breast with gen'l carcinomatosis 1 Year				
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO						
(c) DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) (State)
21. I certify that I attended the deceased from Sept 3, 1942, to Sept 3, 1957, that I last saw the deceased alive on Sept 1, 1957, and that death occurred at 7:30 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 8310, W. Baltimore St.
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) KENNARD YAFFE	M.D.				DATE SIGNED 9/5/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-7-57	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard	ADDRESS 4107 Wilkens Ave.	24a. REC'D BY REGISTRAR DATE 10/26/57	24b. REGISTRAR'S SIGNATURE Dr. George Hubbard			

SEP 6 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09293

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)	
<u>Baltimore</u> MARYLAND		a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<u>Ridgewood</u>	<u>1 month</u>	<u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
<u>Penna Railroad Tracks 1/4 mile west</u>			
3. NAME OF DECEASED (Type or print)	First <u>Grace</u>	Middle <u>Read</u>	Last <u>Thomas</u>
4. SEX <u>Female</u>	5. COLOR OR RACE <u>White</u>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>July 1, 1884</u>	9. AGE (in years birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Oliver Read</u>	14. MOTHER'S MAIDEN NAME <u>Fannie Burchael</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Clarence Thomas, 226 Linden Ave., Towson, Md.</u>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury to Skull</u> DUE TO <u>Sudden</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in part I or Part II of Item 18.) <u>Striking on KIRKIE on left side of head</u>	
20c. TIME OF INJURY Month, Day, Year <u>6/15 p.m. Sept 7 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Railroad track Ridgewood, Baltimore</u>
20f. (City or town) <u>Ridgewood, Baltimore</u>		(County) <u>Baltimore</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles E. Deane Jr.</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Charles E. Deane Jr.</u>	DATE SIGNATURE <u>9/7/57</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 11, 1957</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Slate Ridge Cemetery</u>	22d. LOCATION (City, town, or county) <u>Delta, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons</u>		ADDRESS <u>Towson, Md.</u>	24a. REC'D BY REGISTRAR <u>Sept. 10, 1957</u>
			24b. REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 1 1972

REAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
929 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
<i>Baltimore</i> <i>MARYLAND</i>		<i>Penn.</i> <i>b. COUNTY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkton</i>		c. LENGTH OF STAY IN 1b 0	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Coatesville</i>	

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF DECEASED (Type or print)	First <i>F. L. Lezey</i>	Middle <i>T</i>	Last <i>terres</i>	4. DATE OF DEATH	Month <i>Sept.</i>	Day <i>28</i>	Year <i>1957</i>	
5. SEX	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown</i>	9. AGE (in years last birthday) <i>30 ? yrs.</i>	IF UNDER 1 YEAR Months <i>30</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	11. BIRTHPLACE (State or foreign country) <i>Unknown</i>	12. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>
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13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>816 X</i>	17. INFORMANT <i>Address</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		<i>Nyctaphyl fractures & crushing</i> 0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO <i>body injuries</i>
DUE TO (b)		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Automobile accident</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20c. TIME OF INJURY <i>9/28/57</i>	Month, Day, Year <i>o. m.</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>at 14</i>	20f. (City or town) <i>Parkton</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
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ACTUAL SIGNATURE <i>A. M. France</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>9/28/57</i>
EXAMINER'S NAME (Type) <i>A. M. France</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-14-57</i>	22b. DATE THEREOF <i>10-14-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>II. of Md. Med. School</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chestertown</i>			24a. REC'D BY REGISTRAR <i>10/1/57</i>	24b. REGISTRAR'S SIGNATURE <i>Chestertown</i>

RECORDED
DECEMBER 22, 1957

RECORDED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09295

9292

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Baltimore</i>		c. LENGTH OF STAY IN 1b <i>7 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Randallstown</i>		d. STREET ADDRESS <i>Holbrook, Liberty Rd.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Rachel</i>	Middle <i>Ellie</i>	Last <i>Triplett</i>	4. DATE OF DEATH <i>Sept. 1 1957</i>	Month <i>Sept.</i>	Day <i>1</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 27, 1863</i>	9. AGE (in years last birthday) <i>94 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>	13. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George Bailey</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Beecraft</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>Mrs Austin Boyd. Randallstown, Md.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Vascular Disease</i>						INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. Randallstown</i>		20f. (City or town) <i>Md.</i>		(County) <i>Randallstown</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Aug 20, 1957</i> to <i>Sept 1, 1957</i> that I last saw the deceased alive on <i>Sept 1, 1957</i> , and the death occurred at <i>12:00 A.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Randallstown, Md.</i>		DATE SIGNED <i>Sept 1, 1957</i>
ACTUAL SIGNATURE <i>W. E. Martin</i>								
PHYSICIAN'S NAME (Type) <i>W. E. Martin</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-3-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Wards Chapel</i>		22d. LOCATION (City, town, or county) <i>Baltimore Co., Md.</i>		(State) <i>Md.</i>
23. FUNERAL-DIRECTOR'S SIGNATURE <i>Guthrie A. Height</i>		ADDRESS <i>Sykesville, Md.</i>		24a. REC'D BY REGISTRAR <i>W. E. Martin</i>		24b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELVELL

SEP 4 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09296
45

9293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN 1b 4 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Edgemere	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Convalescent Home				d. STREET ADDRESS 6924 River Drive Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Louis	First	Middle	Last	4. DATE OF DEATH Month September Day 16 Year 1957	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1873	9. AGE (In years (at birthday) 83 yrs.)	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Spanish American		16. SOCIAL SECURITY NO.		17. INFORMANT Gilio Valerio 6924 River Drive Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. 260X (c) DUE TO Heart failure		B bronchopneumonia associated with Congestive Heart failure		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		(1) Diabetes mellitus (2) rheumatoid arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 14th 1957 to Sept 15th 1957 , that I last saw the deceased alive on SEPT 16th 1957 , and that death occurred at 6:20 AM , from the causes and on the date stated above.		ACTUAL SIGNATURE John E. Conner		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)		M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 20, 1957		22c. NAME OF CEMETERY OR CREMATORIAL St. Mary	
22d. LOCATION (City, town, or county) Iron County, Wisconsin		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.		ADDRESS 403 S. Wolfe St.		24a. REC'D BY REGISTRAR DATE SEP 17 1957	
				24b. REGISTRAR'S SIGNATURE Edith Husley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MURRAY K.

SEP 18 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09297
41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		d. STREET ADDRESS 6731 Oak Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6731 Oak Ave.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First CATHERINE	Middle VANEK	Last	4. DATE OF DEATH Sept. 12,	Month 19	Day 57	Year
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> OCT 2 1886	9. AGE (in years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Czechoslovakia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME John Plonk	14. MOTHER'S MAIDEN NAME Agnes Binousky
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO.	17. INFORMANT Alexander Wanek 6733 Oak Ave.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Occlusion</i> (c) <i>As-c-V-Disease</i>		
DUE TO		
DUE TO		
DUE TO		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>As-c-V-Disease</i>					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
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SIGNATURE <i>M B Davis</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>9/15/57</i>
EXAMINER'S NAME (Type) <i>M B Davis MD</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 16, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn	22d. LOCATION (City, town, or county) Colgate, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.	ADDRESS	24a. REC'D BY REGISTRAR RECD 17 1957	24b. REGISTRAR'S SIGNATURE <i>H. Kelly</i>
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RECEIVED

SEP 10 1970

BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Burial-Transit Permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9165

CERTIFICATE OF DEATH

Reg. Dist. No.

092981

2. PLACE OF DEATH a. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN b. 27 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 160 VENTNOR TERRACE		e. STREET ADDRESS 160 VENTNOR TERRACE	
3. NAME OF DECEASED (Type or print) JAMES		First EMIL	Middle WEATHERLY
3. NAME OF DECEASED (Type or print) JAMES		Last WEATHERLY	4. DATE OF DEATH 9/22/1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 29, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEAR OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY STEEL MFG.R.	11. BIRTHPLACE (State or foreign country) N. CAROLINA
13. FATHER'S NAME JOE WEATHERLY		14. MOTHER'S MAIDEN NAME EMMA GILBERT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO		16. SOCIAL SECURITY NO. 313-07-3963	17. INFORMANT IRENE F. WEATHERLY — SAME
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor		6 mo.	
DUE TO 163X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Lungs		6 mo.	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1956 to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at _____, 1957, M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 2900 Dunton Rd.	
ACTUAL SIGNATURE B.W. Sollod		DATE SIGNED 2900 Dunton Rd.	
PHYSICIAN'S NAME (Type) B.W. SOLLOD, M.D.			
22a. BURIAL, CREMATION, Crematory (Specify) BURIAL		22b. DATE THEREOF 9/25/57	22c. NAME OF CEMETERY OR CREMATORIUM OAKDALE
23. FUNERAL DIRECTOR'S SIGNATURE Walter Joseph Bradley, Glenelg, Md.		24a. ADDRESS 150 W. Main St., Glenelg, Md.	24b. REG'D BY REGISTRAR SEP 25 1957
		REGISTRAR'S SIGNATURE John Kelly	

BUREAU N.Y.

SEP 25 1957

REGELIVE

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9294

Items 1-9 File No. 220 9-12-47 et

CERTIFICATE OF DEATH

09294
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		b. STATE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. COUNTY					
BALTIMORE		MARYLAND		MD.		BALTIMORE		RURAL - ROCKDALE		BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		31 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		RURAL - ROCKDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
RURAL - ROCKDALE		31 YRS.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Private		d. STREET ADDRESS		3522 ST. JAMES RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year							
GEORGE				WASHINGTON WEAVER	9	9	1957								
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
M		W	DON'T KNOW	APPROX.		71	Months	Days	Hours	NOT KNOWN	NOT KNOWN	NOT KNOWN	NOT KNOWN	MR. GARNER	1107 HAMPTON GARTH, TOWSON 4.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
STATIONARY ENGINEER		—		BALTIMORE, Md.		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
NOT KNOWN		NOT KNOWN		NOT KNOWN		NOT KNOWN		NOT KNOWN		CONGESTIVE HEART FAILURE		ONE YEAR			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY		Month	Day	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
				Hour	a. m.	19			While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>						
21. I certify that I attended the deceased from		9/10		1957		to		9/9		1957		that I last saw the deceased alive on		9/5/57	
ACTUAL SIGNATURE		EDWIN L. PIERPOINT		MD.		ADDRESS (Street, city or town, state)		DATE SIGNED		EDWIN L. PIERPOINT, MD.		9/11/57			
PHYSICIAN'S NAME (Type)		EDWIN L. PIERPOINT, MD.		22a. BURIAL, CREMATION, REMOVAL (Specify) ✓		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
		9/12/57		✓		U. of Md. Med. School		Baltimore, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									

RECEIVED
BUREAU V. S.

SEP 17 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9295

CERTIFICATE OF DEATH

09300

Reg. Dist. No.

38

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. II institution: Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Towson Convalescent Home</i>		d. STREET ADDRESS <i>5704 The Alameda Blvd</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>RHODA</i>	Middle <i>PENELOPE</i>	Last <i>WHITEHORN</i>	
4. DATE OF DEATH	Month <i>Sept</i>	Day <i>4</i>	Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 7, 1882</i>	
9. AGE (In years last birthday) <i>74</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Linwood, N.Y.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Wood</i>	14. MOTHER'S MAIDEN NAME <i>Araminta Swan</i>	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>104-09-3681P</i>	17. INFORMANT <i>Miss Catharine Whitehorn</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arterio-sclerosis, general</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs?</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Oct 1957</i>	(County) (State)
21. I certify that I attended the deceased from <i>Oct 1957</i> to <i>Sept 4, 1957</i> , that I last saw the deceased alive on <i>Aug 31, 1957</i> , and that death occurred at <i>5 A.M.</i> from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>Catharine Whitehorn, M.D.</i>	ADDRESS (Street, city or town, state) <i>1041 St. Paul St., Baltimore, Md.</i>			DATE SIGNED <i>9/5/57</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>Sept 6, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Green Mount Crematory</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins, Son, Ca.</i>		ADDRESS <i>4905 York Road</i>	24a. REG'D BY REGISTRAR DATE <i>SEP 6 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>

1961 A.D.

756

DEPARTMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57 et
CERTIFICATE OF DEATH

09301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Baltimore 22 MARYLAND		as	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Dundalk		W	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
55 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
4065 Old North Pt. Rd.		#1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
John		W	IDRANSKY
4. DATE OF DEATH		Month	Day
Sept 29		1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Dots Hours Min.
Sept. 18. 1884		73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Steel worker		Beth Steel Co.	Austria
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Vidransky		Mary Baca	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		213-07-5237	Cecilia Vidransky (wife) #1
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Adeno Carcinoma Esophagus 4 mo.	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Pulmonary edema			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 13, 1957, to Sept 29, 1957, that I last saw the deceased alive on Sept. 29, 1957, and that death occurred at 3 P. M., from the causes and on the date stated above. ACTUAL SIGNATURE Louis N. Tolin M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Louis N. Tolin - Baltimore 19 - DATE SIGNED 9/29/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart of Mary
22d. LOCATION (City, town, or county) German Hill Rd. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 2829 Hudson St. 24, Md.		24a. REC'D BY REGISTRAR DATE 10/1/57	24b. REGISTRAR'S SIGNATURE John J. Duda

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELIVEL

V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09302

9296

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex Life		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 351 Savannah Rd.		d. STREET ADDRESS 351 Savannah Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frederick C. Wilhelm		First Middle Last	4. DATE OF DEATH Sept. 14, 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1882
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent Retired		10b. KIND OF BUSINESS OR INDUSTRY Life Insurance	11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Wilhelm		14. MOTHER'S MAIDEN NAME Emma Wolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Charles C. Wilhelm 351 Savannah Rd. (21)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>4120.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Heart Block 2nd degree</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 1957 to <u>Sept 15</u> , 1957, that I last saw the deceased alive on <u>Sept 14</u> , 1957, and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Baltimore 6 Md.</u> DATE SIGNED <u>9/16/57</u>	
ACTUAL SIGNATURE <u>G. M. Baumgardner</u>		PHYSICIAN'S NAME (Type) G. M. Baumgardner	
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 18, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore	22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	24o. REC'D BY REGISTRAR DATE <u>SEP 18 1957</u> <u>Edith Turley</u>
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVE

SEP 19 1957

BUREAU X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09303

9297

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville	c. LENGTH OF STAY IN 1b 8mths26dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL	d. STREET ADDRESS 729 Newington Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ada	First Middle Lester	4. DATE OF DEATH Septembe 12 1957	Month Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		9. AGE (In years last birthday) 89 yrs	10f. UNDER 1 YEAR Months Days Hours Min.
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Mary Jane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Several weeks	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Arteriosclerosis of coronary arteries several years	
DUE TO (c) Generalised arteriosclerosis		many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 26, 1956 to 9/12, 1957, that I last saw the deceased alive on 9/12, 1957, and that death occurred at 9:15 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE BRUNO RADAUSKAS M.D.	SPRING GROVE STATE HOSPITAL		
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS	Catonsville 28, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-16-57	22c. NAME OF CEMETERY OR CREMATORIUM Parkwood	22d. LOCATION (City, town, or county) Baltimore (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joe L. Raduska	ADDRESS	24a. REC'D BY REGISTRAR DATE SEPT 14 1957	24b. REGISTRAR'S SIGNATURE R.W. O'Brien
SEP 16 57			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N.Y. 2
RECEIVED

SEP 17 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09304

9298

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>life</i>	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <i>None 9710 Harford</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lydia Maud Wilson</i>		First <i>Lydia</i>	Middle <i>Maud</i>
		Last <i>Wilson</i>	4. DATE OF DEATH <i>Sept 30 1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 1 1862</i>
9. AGE (In years lost birthday) yrs. <i>95</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>None</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Edward Morris</i>	14. MOTHER'S MAIDEN NAME <i>Anna Oliver</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Joseph O. Wilson 9710 Harford Rd</i>	17. INFORMANT <i>Address</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>571.1</i> DUE TO <i>Diseased Degeneration + Senility</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Age</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc. <i>None</i>
21. I certify that I attended the deceased from alive on <i>Sept 26 1957</i> , and that death occurred at <i>7:00 P.M.</i> from the causes and on the date stated above.		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>FRANK T. KODIR JR.</i>		ADDRESS (Street, city or town, state) <i>905 Harford Rd BALTO MD</i>	
PHYSICIAN'S NAME (Type) <i>FRANK T. KODIR JR.</i>		DATE SIGNED <i>14 Nov 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>Oct 3 - 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>David Ridge</i>		22d. LOCATION (City, town, or county) <i>BALTO Co</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>CHAS F. EVANSTON</i>		24a. REC'D. BY REGISTRAR DATE <i>Dr. G. M. Bacon</i>	
ADDRESS <i>8802 Harford Rd</i>		24b. REGISTRAR'S SIGNATURE <i>EJ</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL BUREAU OF INVESTIGATION

OCT 3 1957

FEDERAL BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09305

9299

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>		d. STREET ADDRESS <u>STEVENSON RD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ARMACOST NURSING HOME</u>				d. STREET ADDRESS <u>STEVENSON RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>STELLA</u>	Middle <u>MIDDLETON</u>	Last <u>WILSON</u>	4. DATE OF DEATH <u>SEPT. 30</u>	Month <u>1957</u>	Day	Year		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 17, 1880</u>	9. AGE (In years last birthday) <u>76 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u>	IF UNDER 24 HRS. Days <u>0</u>	Hours <u>0</u>	Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>CHARLES WILMER MIDDLETON</u>		14. MOTHER'S MAIDEN NAME <u>EMILY POLK</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS GAINES MAC MILLAN</u>		Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180X</u> DUE TO <u>Hypertension</u> 6 mos.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Metastasis</u> 3 mo. (c) <u>Arterio - sclerosis</u> 10 yr.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>PIKESVILLE</u>		(County) <u>8</u>	(State) <u>M.D.</u>
21. I certify that I attended the deceased from <u>Sept. 10, 1948 to Sept. 30, 1957</u> , that I last saw the deceased alive on <u>Sept. 30, 1957</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Patricia F. Wilkins</u> ADDRESS (Street, city or town, state) <u>PIKESVILLE 8-1101</u> DATE SIGNED <u>10/4/57</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>ST. THOMAS</u>		22d. LOCATION (City, town, or county) <u>GARRISON FOREST</u>		(State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN C. MITCHELL & SONS</u>		ADDRESS <u>1900 EUTAW PLACE</u>		24a. REC'D BY REGISTRAR <u>10/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEADER V. S

DET

WISCONSIN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09306

9300 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	c. LENGTH OF STAY IN 1b Life	b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION COLLEGE MANOR	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Virginia Appleton Wilson	First V	Middle I	Last Wilson
4. DATE OF DEATH Sept 8 1957	Month Sept	Day 8	Year 1957
5. S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTO MD
			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME J Appleton Wilson	14. MOTHER'S MAIDEN NAME MARY WADE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. —	17. INFORMANT MRS DAVID P BARRETT	Address RUXTON MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X		INTERVAL BETWEEN ONSET AND DEATH Plural Effusion - malignant? 9 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause first. (b) DUE TO Senile Mental Deterioration - vascular		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ Jan 1957, to _____ Sep 1957 that I last saw the deceased alive on _____ Sept 7, 1957, and that death occurred at _____ M. Nam the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Valerie A. Baetjer		M.D. 1101 St Paul St	
PHYSICIAN'S NAME (Type) VALIER A BAETJER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 12/57	22c. NAME OF CEMETERY OR CREMATORIUM Green Mount	22d. LOCATION (City, town, or county) BALTO MD (State)
23. FUNERAL DIRECTOR'S SIGNATURE Hankins Smo 4905 York Rd		ADDRESS 1101 St Paul St	24a. REC'D BY REGISTRAR DATE SEP 12 1957
			24b. REGISTRAR'S SIGNATURE Deborah

"In my opinion....'cancer of the pleura'.....

Dr.W.A.B. 9-13-57 ams

BUREAU V. S.

SEP 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09307

9301

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 409 Babikow Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
3. NAME OF DECEASED (Type or print) George C. Winterstein		d. STREET ADDRESS Box 409 Babikow Rd.	
4. DATE OF DEATH Sept. 25 1957		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
10c. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Winterstein		14. MOTHER'S MAIDEN NAME Johanna Kern	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Matilda Winterstein		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema; Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Severe Anemia DUE TO (c) Metastatic Osteo Chondro Sarcoma	
		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ July 1957 to Sept. 1957, that I last saw the deceased alive on _____ 24 Sept 1957, and that death occurred at 1 P.M., from the causes and on the date stated above. MEDICAL SIGNATURE John C. Hyde, M.D.		DATE SIGNED 7-26-57	
PHYSICIAN'S NAME (Type) John C. Hyde		M.D. 7527 Belair Rd Balto. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 28, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Belair Memorial Gardens		22d. LOCATION (City, town, or county) Belair, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ezra's Funeral Home		ADDRESS 7401 Belair Rd	
24a. REC'D BY REGISTRAR DATE EP 30 1957		24b. REGISTRAR'S SIGNATURE Mr. A. L. Leibman	

EURILIU V. S

CEP 00000-000

BRASIL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10042

Reg. Dist. No.

ITEMS: 3, 8, 13, 14, 22b, 9;
Film G 221, 937552L

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 46yr3mth23dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	ALSO KNOWN AS William	First Middle ISMA WYATT	4. DATE OF DEATH Sept. 30
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) horse dealer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 82 817 yrs.
		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? Maryland
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown / Annie Scarborough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		Cardiac failure	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Arteriosclerotic cardiovascular disease	
DUE TO (b) DUE TO (c)		Generalized arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 30, 1957 , to Sept. 30, 1957 , that I last saw the deceased alive on Sept. 30, 1957 , and that death occurred at 4:00 p.m. , from the causes and on the date stated above.		DATE SIGNED 4:00p.m. ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Stella Wachsler		M.D. SPRING GROVE STATE HOSPITAL 9-30-57	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Sept. 30, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Greenwood Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Stewart Wachsler	ADDRESS 108 W North St.	24a. REC'D BY REGISTRAR DATE OCT 2 '57	24b. REGISTRAR'S SIGNATURE Aut. Coach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF DEFENSE
CERTIFICATE OF DEATH

WORLD WAR II STATE DEATH CERTIFICATE FORM - 1945 EDITION

BUREAU V. S.
RECEIVED
OCT 2 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09308

9303

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 Vol-4				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 642 So. Ellwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) JOSEPH		First	Middle E.	Last	4. DATE OF DEATH September 5 1957	Month	Day	Year		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1898		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Cleaning & Pressing		11. BIRTHPLACE (State or foreign country) Mielec, Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Frank Wrzask		14. MOTHER'S MAIDEN NAME Anna Kcala								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I None		17. INFORMANT Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X CEREBRAL HEMORRHAGE, LEFT DUE TO CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } DUE TO ESSENTIAL HYPERTENSION (c)						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS				
						UNKNOWN				
						UNKNOWN				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. 19 P. m.		Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from September 4, 1957 to September 5, 1957 , and attended the deceased and that death occurred at 6:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Irving Freeman</i>						ADDRESS (Street, city or town, state) VAH Ft. Howard, Md		DATE SIGNED 9/5/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 9, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Holy Rosary		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lilly & Zeiler Inc., Eastern Ave & Wolfe Sts. Balto. Md</i>		ADDRESS		24a. REC'D BY REGISTRAR 9/6/57		24b. REGISTRAR'S SIGNATURE <i>Dorothy L. Farley</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

SEP 9 1952